Item1 10-13-95 FilmG728 W.H.Per F/H

1 -	STATE			OIMIL	O1	man Dan						EATH	MENTAL	REG. NO.
	FOR					MARYLAN								HYGIENE
		ITEMS:	23	PART I.	27.	. 28a-f.	PER	ME 0	FILM	G - 7	29 1	11/8/95	t.t	

	nedio i nan				CENTIF	CALL	E OF	DEATH		HEG. NO			
	1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE	OF DEATH		3.	IME OF DEATH
	WILLIE G	uillen	mo ORI.	ANDO			S	AEZ	MONT	DBER D		YEAR 1	1:53 P.
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	-	IF UNDER 24 HRS		OF BIRTH			CE (State or Foreign
	219-19-7419 1 ☑ M 2 □ F 21				YRS.	MONTHS	DAYS	HOURS MIN	(Mont	30, 19	1	Chile	
	9a. FACILITY NAME (If not in:	stitution, give str	eet and number)			9h CITY	/ TOWN (OR LOCATION OF		50, 1	-	TY OF DEATH	
Œ													
6	NORTHWEST		ITAL CE	NTER		R	AND.	ALLSTO	WN		BAI	TIMO	RE
DIRECTOR	10a. STATE	10b. COUNTY			10c, CIT	Y, TOWN	OR LOCAT	ION				100	, INSIDE CITY
듬	Maryland	Baltin	nore		l R	eist	erst	own				10	LIMITS? YES 2 KNO
	10e. STREET AND NUMBER						10	. ZIP CODE			10g. CITIZ	EN OF WHAT	
	14 Glouces	ster Ci						21136			US	Δ	
FUNERAL	1t. MARITAL STATUS		tz. WAS DECEDENT	EVER IN U.S.	ARMED	t3.	WAS DEC	ENDENT OF HIS	PANIC ORIGI	N? (Specify Yes		_	American Indian,
	1 Never Married 2	Married	FORCES? 1 IF YES, OIVE W		MNO		If yes, sp	ecify Cuban, Mar 2 NO Sp	dean, Puerto			Black, Wi Specify:	nite, etc.
B	3 Widowed 4 Divo	rced	1120, 0112 11	WI ON DAILD			I (A) IES	2 NO 3p	South	Ameri	can	эрвспу.	Hispanic
G		EDENT'S EDUC		16a.	DECEDENT'S	USUAL C	CCUPATION	ON	161	. KIND OF BU	SINESS/INDU	STRY	
m	Elementary/Secondary (0	-	College (1-4 or 5+	,	life. Do NOT u	se retired.)	ounny mo	st or working					
릴		2	years		Studen	t				Colleg	e		
COMPLETE	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOTHER'S	NAME (First,	Middle, Maiden	Sumame)		
ш	Sergio Sa	ez						Eva	Soled	ad			
8	19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRES	S (Street I	ind Number or Ru	ral Route Nun	ber, City or Tow	rn, State, Zip	Code)	
2	Mr. Sergio	Saez			14 G1	ouce	ster	Ct. I	Reiste	rstown	, MD	2113	6
	20s. METHOD OF DISPOSIT				CEANDDATE	OF DISPO	SITION (N		DAT		CATION - C		
	1 X Burial 2 Cremation 4 Donation 6 Other		vei from State	Ever	Evergreen Memorial Park 10-7 Finks					nksbu	rg. Ma	rvland	
	21. SIGNATURE OF FUNERA					22.	NAME A	ND ADDRESS OF	FACILITY				
	Sorlin	-14.1	And))				g Byers					
								Liberty					
	23. PART I. Enter the di ahock, or he	eart fallure. I	lst only one csu	se on each	line.	not ente	r the mo	de ot dying, s	uch sa car	disc or resp	Iratory sm	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Fir disesse or condition	nel	200										Onset and Death
	resulting in desth)												
			DUE TO	OR AS A COP	SEQUENCE C	F):							
ᇹᅵ	Sequentially list conditi	lons,	DUE TO	OR AS A COA	SEQUENCE C	6.				_			
CERTIFICATION	if sny, lesding to imme- ceuse. Enter UNDERLYI		DOE TO	(OR AS A COP	ISEOUENCE C	r):							
윤	CAUSE (Disease or Inju		DUE TO	OR AS A COR	ISEQUENCE O	f i:							
Ē	that initiated events resulting in desth) LAS	т				. ,,							
E C			J						-				
	PART II. Other significe	ent condition	contributing to	death but n	ot resulting	In the u	nderlyln	g cause given	In Part I.	24a. WAS AN			RE AUTOPSY FINDINGS
DICAL										1 X YES		co	MPLETION OF CAUSE DEATH?
Ш										X			YES 2 NO
2	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF D	EATH Y	ES 🗆	NO [UNCERT	AIN 🗆				3
AN	25. WAS CASE REFERRED T	O MEDICAL	-	26. F	PLACE OF DEA	TH (Check	only one						
SICI	EXAMINER?		HOSPITAL:	VER/Outpatian	t 3 🗆 DOA	OTHE 4 Nu		te 5 🗆 Raalden	ca & C Oth	er (Specific)			
PHY	27. MANNER OF DEATH		28a. DATE OF	INJURY	FÖUN		26c. IN.	JURY AT		SCRIBE HOW	INJURY OCC	URED	
		Pending Investigation	FOUND:		FOUNT)URY 45 PM	1 🗆	ORK? YES 2 X XNO	UNK	NOWN			
2 Accident investigation 2 and 100 Million at home from plant forther affiles									Number				
City or Town, State) 14 GLOUSTER COURT									COURT				
Ш						-110-			REIS	ICKSTON	п. пр.		
	4 Homicide	determined	MAN. Y- 11- 1- 1- 1										
	4 Homicide 29a. CERTIFIER (Check only opening of the control of the centre of the cen	detarmined	CIAN: To the best of	my knowledge							nner as state		
COMPLETE	4 Homicide 29a: CERTIFIER (Check only one) 2 MED	determined TIFYING PHYSIC ICAL EXAMINE	R: On the beals of a	my knowledge				death occured at	the time, det		nner as state		d menner as stated.
E COMPLET	4 Homicide 29a. CERTIFIER (Check only opening of the control of the centre of the cen	determined TIFYING PHYSIC ICAL EXAMINE	R: On the beals of a	my knowledge					the time, det		nner as state	cause(a) an	d menner as stated.
BE COMPLET	4 Homicide 29a. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE	TIFYING PHYSII	Con the basis of a	my knowledge ramination and	d/or Investigati	on, in my		Jesth occured at 29c. LICENSE	the time, det	a and place, a	nner as state nd dua to the 29d. DATE	SIONED (Mo	
E COMPLET	4 Homicide 29a: CERTIFIER (Check only one) 2 MED	TIFYING PHYSII	Con the basis of a	my knowledge	(ITEM 27) (Type	on, in my	opinion,	29c. LICENSE	the time, det	a and placa, a	nner as state and due to the	SIONED (MC	4 , 1995
BE COMPLET	4 Homicide 29a. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE	determined TIFYING PHYSII ICAL EXAMINE OF CERTIFIEF F PERSON WHILE A.C. A.	Con the basis of a	my knowledge camination and	(ITEM 27) (Type	on, in my	opinion,	29c. LICENSE	the time, det	a and placa, a	nner as state and due to the	SIONED (MC	onth, Day, Year)

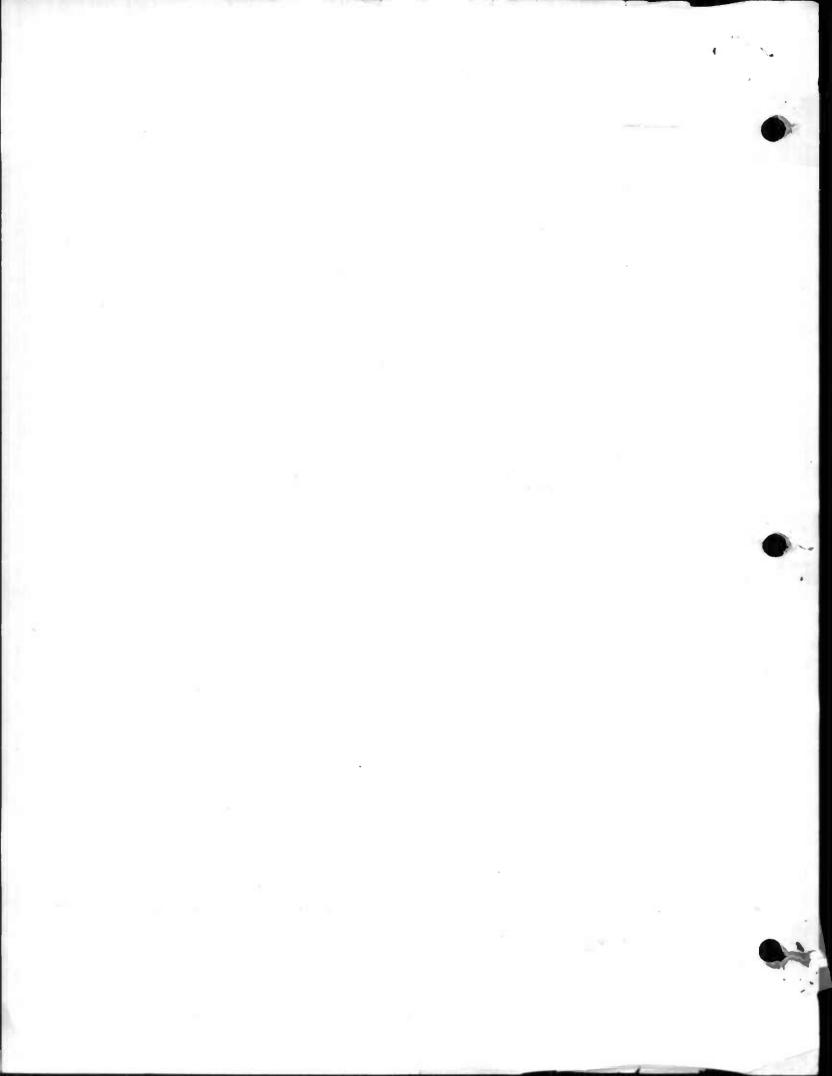
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flow is a fine death of the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

OCT 1 2 1985 Juli Studier Rankell



e retained by the hospital or attending physician.	5 Should be detached for use as the burial-tran		sandlifted at seven
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burita-tran	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	12MT Hitem 28 to marked or Hem 22 shows one Internet or ather tenemals around the madical averaging an action of the made of the second of the
HOSPITAL	FUNERAL	within 72	TAMT. 19

permit. Pages 1, 2, 3 should

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CERTIFICATION

PHYSICIAN: MEDICAL

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TO THE HOSPITAL TO THE FUNERAL OF the within 72 h

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Warren Darlington Smith October 10 1995 4:00 P M 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 200-01-5121 1 X M 2 - F 75 December 19 1919 Pennsylvania 9e. FACILITY NAME (If not institution, give street and number 9b. CITY TOWN OR LOCATION OF BEATH 9c. COUNTY OF DEATH 2216 Ken Oak Road Baltimore N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland N/A Baltimore 1 X YES 2 | NO 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2216 Ken Oak Road 21209 United States 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WORLD WAR II 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-I1 yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married YES 2 X NO Specify: 3 X Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 165 KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) 8 Iron Worker Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Surname) Alfred Eugene Smith Mary Porter 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel G. Davidson 2309 Crest Road Baltimore, Maryland 20a. METHOD OF DISPOSITION
1 □ Burlel 2 🕱 Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 4 Donation 5 Other (Specify) Greenmount Crematory 10/14 Baltimore, Maryland 21. SIGNATURE OF THERAL SERVICE LICENSES 22. NAME AND AGORESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Betwe **IMMEDIATE CAUSE (Finel** Onset and Death Cardio sulmonary resulting in death) hours DUE TO (OR AS A CONSEQUENCE OF): Hegelic Fuelus Sequentially list conditions, If any, leading to immediate Kypato cellule OUE TO (OR AS A CONSEQUENCE OF): . Enter UNDERLYING CAUSE (Disesse or Injury ar that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home SA Reeldence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 ___ MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

> M.D. 22 North Greene Street Baltimore, Maryland 21201

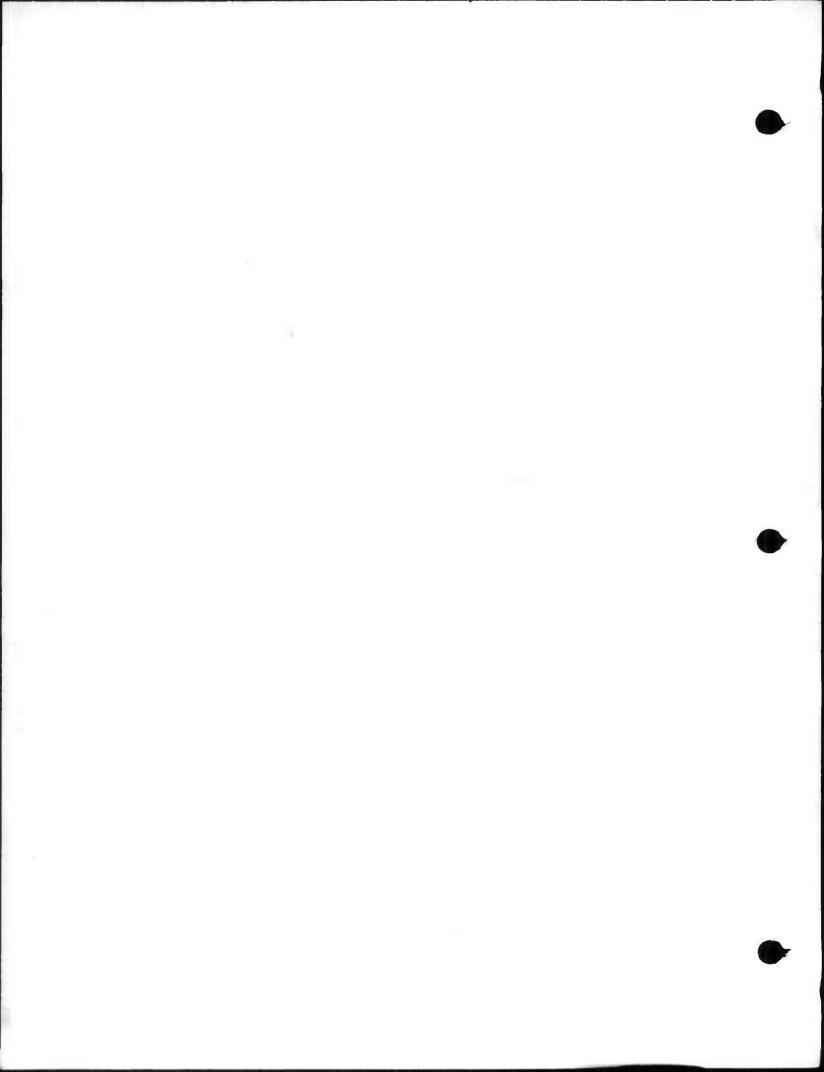
Michael Gallegher, 31. DATE FILEO (Month, Day, Year)
QCT 1 3 1995 32, REGISTRAR'S SIGNATURE

38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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October 13, 1995



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MARYLAND 21215-0020	
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH MONTH. HIPLE Thomas 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 1 - M 2 F DAYS DEC. Pages 1, 2, 3 should Da. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR TIMOVE RESIDENCE EDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION to more Ka lazis permit. FUNERAL 10a. STREET AND NUMBER 10f, ZIP CODE 39 12/6 and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit orientation, or removal. 06 attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuhan, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married FORCES? 1 YES 2 NO BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EQUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most life. Do NOT, use retired.) >> (Specify only highest grade 6 Elementary/Secondary (0-12) College (1-4 or 5+) HOW the hospital 124 XASIT 17. FATHER'S NAME First, Middle, (Last) notified at hours after death. Page 6 may be retained by BE 19a. INFORMANT'S NAME (Type/Print) 2 10a. METHOD OF DISPOSITION 9 20b. PLACE AND DATE OF DISPOSITION (Nam must Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FMNERAL SERVICE LICENSEE Herris HATMM medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finsi the disease or condition executed within 24 Carcinoma resulting in deeth) traumatic event, CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): the attending physician at Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING the death certificate be other 1 CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Thrombophle 6 any Injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY DIRECTOR: After this certificate has been signed by hours after death with the State Dept. of Health and requires that 1 YES 2-14 shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL The ltem . 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 NO ATTENDING PHYSICIAN: 1 Inputient 2 ER/Outpatient 3 DOA 4 - Nursing Name 5 Residence 6 - Other (Specify) 5 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b, TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) -3 Suicide COMPLETED 6 Could not be 4 Nomicide 28 8 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
DE filed within 7. 2 ___ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as attend. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER H 9

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

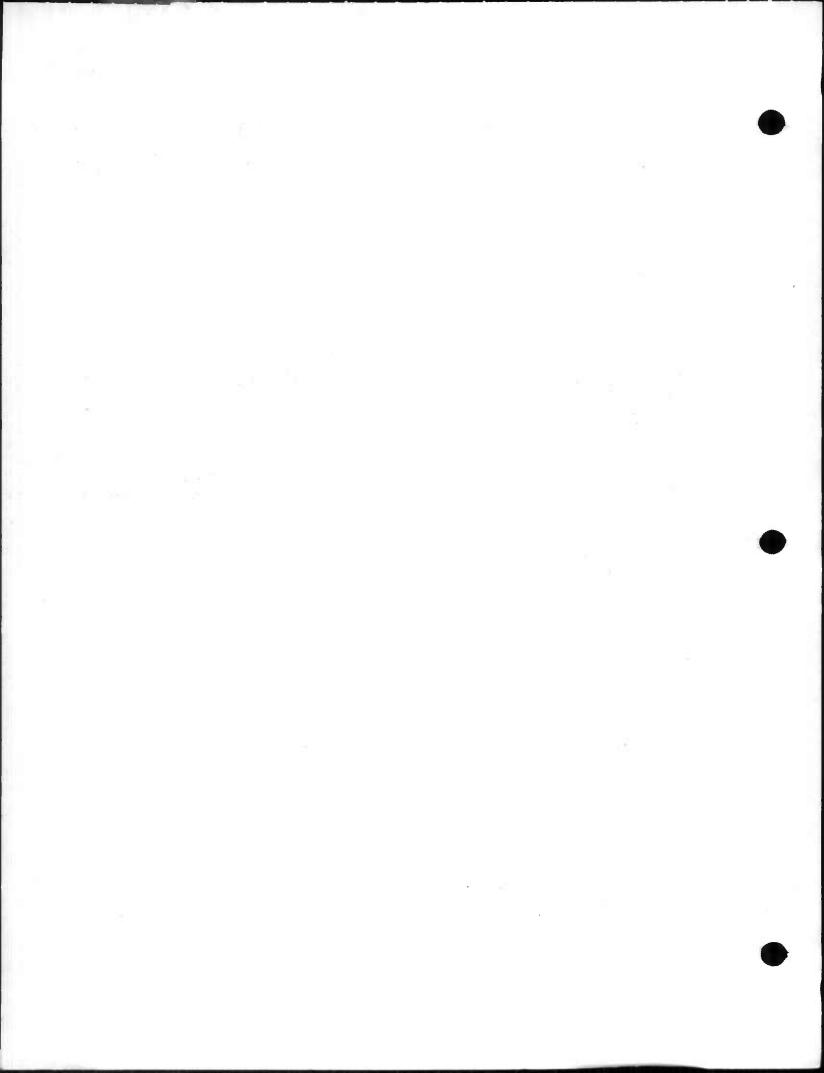
4660 Wilkens Ave

Gebremariam

31 OCT 1 3 1995

CERTIFICATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 3. TIME OF DEATH 995 S. BIRTNPLACE (State or Mary pro 9c. COUNTY DE DEATH N 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, atc. 16b. KIND OF BUSINESS/INOUSTRY Vasim May kons 12/2/2/1 Approximata interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 6 95



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	1. DECEDENT'S NAME (First, Middle, Last)	CLRIII	TICATE OF	DEATH	2. DATE OF DEATH	AY	VEAD 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	October 7. DATE OF BIRTH	11 /	775	12427
	214-18-5598 1XM2DF 7		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)	ACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF D			TY OF DEAT	
CTOR	Caton-Meridian Manor		Balti	more Ci	ty		N/A	
DIREC	10a. STATE 10b. COUNTY	10c. Cl	TY, TOWN OR LOCA	ATION			10	d. INSIDE CITY LIMITS?
	Md N/A	Ba	altimor					YES 2 NO
Y L	152 Irving StBaltimor	o W.d	1	of. ZIP CODE				T COUNTRY?
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DE	21229 CENDENT OF HISPA	VIC ORIGIN? (Specify Yes		S.A.	American Indian,
10	3 Widowed 4 Discoved	2 NO ATES		S 2 NO Specific	n, Puerto Ricen, etc.)		Specify:	Thite, etc.
	15. DECEDENT'S EDUCATION	18a. DECEDENT'S	S USUAL OCCUPAT	TON	16b. KIND OF BUS	SINESS/INDU		hite
LETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during man retired.)	nost of working				
	Grade 8 17. FATHER'S NAME (First, Middle, Last)	Roofe	er			Het	zzel	
E COMPL	Benjamin Taylor				ME (First, Middle, Meiden	Sumame)		
2	19a. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street		Route Number, City or Town	n, State, Zip C	Code)	
_	Mary D. Taylor				212-Ba	lto.	.Md.	21227
k	1 Burial 2 Cremation 3 Removal from State can	netery, crematory or				CATION — CI		
į	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	oudon I	22. NAME A	M. 10-14	CILITY	Balto		
	G. Truman Schwab	com			ore Nati		Pik	e
	23. PART t. Enter the diseases, or complications that cause shock, or heart feliure. List only one cause on e	the deeth. Do	not enter the m	ode of dying, suc	Md. 2122 h as cardiac or reapi	ratory arres	et,	Approximata
	MANAGOVATE CALLOG (ET.)		10	\	11			Onset and Da
I)	disease or condition resulting in death)	car	dine	arrhi	athmia	_	~	nenutes
	disease or condition resulting in death) a. Probable DUE TO (OR AS	ado	no ca	reinon	a Left	lun	4	month
CALIDA	if any, leading to immediate	CONSEQUENCE C	PF):				8	
3	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A	CONSEQUENCE C	PF):					
CERTIFI	resulting in death) LAST							
	PART II. Other algnificant conditions contributing to deeth b	ut not resulting	in the underlyir	ng cause given in	Part i. 24e. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDIN
DICAL	history chronic 06	struct			PERFOR	MEO?	CO	MILABLE PRIOR TO MPLETION OF CAUS DEATH?
Z				0				YES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE O		ES NO [121		<u></u>	
SICIA	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outp		OTHER:	me 5 🗆 Residence	8 Other (Specify)			
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIR	AE OF 28c. IN	JURY AT ORK?	28d. DESCRIBE HOW II	NJURY OCCU	RED	
5	2 Accident Investigation	— At home form		YES 2 NO	444 LOOJEION (7)			
	4 Homicide detarmined building, stc. (Spec	offy)	street, ractory, orni		28f. LOCATION (Street a City or Town, State)	nd Number or	Rural Houti	Number,
	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my know	ledge, death occur	red at the time, dat	s and place, and due	to the cause(a) and men	mer as atated	i.	
	one) 2 MEDICAL EXAMINER: On the beels of examination							d menner es stated
	296. SIGNATURE AND TITLE OF CERTIFIER	0.0		29c. LICENSE NUM	IBER D	29d. DATE S	SIGNEO (Mo	onth, Day, Year)
	30. NOTE AND ATORESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	o, Print)	レみつ	101	- 10	115	1.57
	J.D. Skarbek, M.D.	8418	B+A	Blud.	Pasada	re /	nd.	21122
	31. DATE FILEO (Month, Day, Year) 32. REGISTRARS SIGN	ATURE				/		

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2. DATE OF DEATH

STATE REGISTRAR

31. DATE FILEO (Month, Day, Ye OCT 1 3 1995

t. DECEDENT'S NAME (First, Middle, Last)

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Tansil1 Oct.7,1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year t [] M 27 DAYS HOURS 214-03-7143 78 Nov.30,1916 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR 518 E.Fort Ave. permit. Pages 1, 2, 3 Balto.City, Md. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland none Balto.City, Md. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 518 E.Fort Ave. page 5 should be detached for use as the burial-transit 21230 the hospital or attending physician. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
 The Yes ZYN NO Specify: 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES t Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12th.Grade none Shofer's Funniture Co Book Keeper 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 3 William BE Tansi11 Katherine L. Mitchell notified retained 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Melvin E. Tansill Sr. 125 W.Ostend St.Balto.Md.21230 Page 6 may be P 20s. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE director, i must Cedar Hill 4 Donation 8 Other (Specify) Cemetery, 10/12/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Balto.Md.21230 eath. in Mare McCully Funeral Home. 130 E. Fort Ave the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 6 shock, or heart failure. List only one cause on each line. 8 filled **IMMEDIATE CAUSE (Final** cremation. event, the disesse or condition Chyncoly w completely resulting in death) DUE TO (CIR AS A CONSEQUENCE OF) and com DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, 2 if any, leading to immediate cause. Enter UNDERLYING attending physician ntal Hygiene prior to valled CAUSE (Disease or injury other that initiated events resulting in death) LAST 10 the atten Mental F Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL A Pa any signed Health 1 YES 2 NO shows a been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN PHYSICIAN: UNCERTAIN [Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate I HOSPITAL: OTHER: 1 TYES 2 | NO t | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Hursing Home 5 N Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this with marked, INJURY 1 W Natural Pending 1 YES 2 NO В After 1 Investigation 2 Accident 28s. PLACE OF INJURY — At home, tarm, street, tactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 6 Could not be DIRECTOR: 10 THE FUNERAL DIRECTOR TO THE FUNERAL DIRECTOR THE FINE WITHIN 72 hours after TANT: If Item 27 4 Homicide 28 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND THE OF CENTIFIER 29c. LICENSE NUMBER BE Ward 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10 3001

32. REGISTRAR'S SIGNATURE Davidson Radall

Madeline

Α.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

3. TIME OF DEATH

M

1:50

tod. INSIDE CITY

t X YES 2 NO

8. BIRTHPLACE (State or Foreign

Maryland

9c. COUNTY OF DEATH

None

20c. LOCATION - City or Town, State

MODAL

PERFORMED?

10g. CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, etc.

Specify White

A.A.Co.Md.

Approximate

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

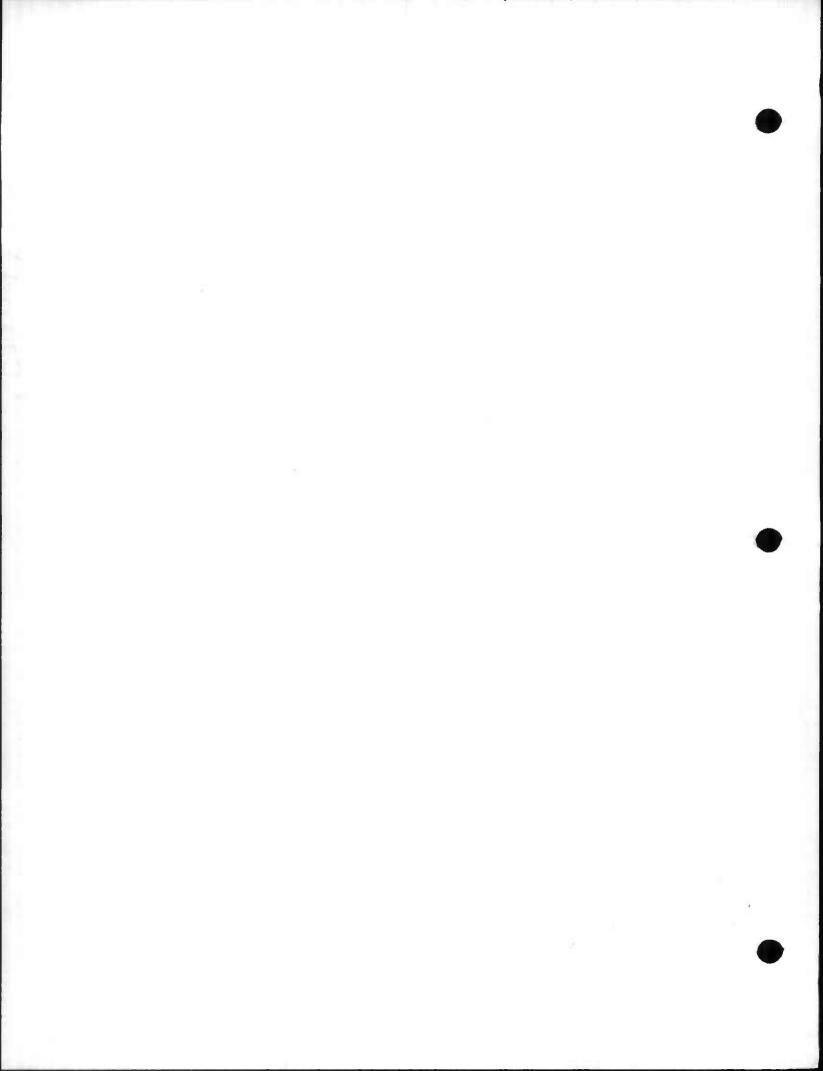
29d. DATE SIGNED (Month, Day, Year)

9

10

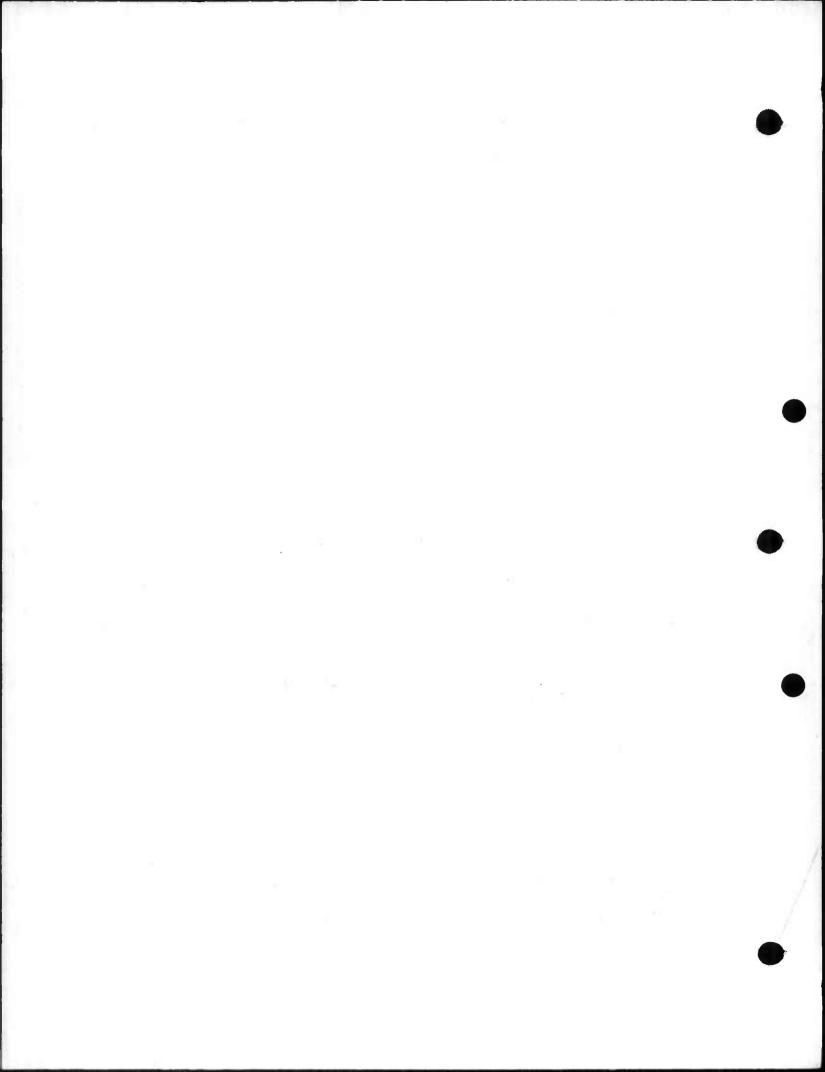
COMPLETION DF CAUSE

Onset and Desth



BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacthed for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	

	FOR STATE REGISTRAR	STATE OF MA			TMENT OF			MENTAL HYGIEN	_		1000
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
	BEVERLY	THOR	NHIL	-1_				OCT 1	Th	YEAR	19. 42 24
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las		IF UNDER 1 YEAR	_	ER 24 HRS.	7. DATE OF BIRTH		B. BIRTHP	LACE (State or Foreign
	218-36-4523	1 M 2 F	56	YRS.	MONTHS DAYS	HOURS	MIN.	(Month, Day, Year)	020	Country)	
	9a. FACILITY NAME (If not institution, give stre	eet and number)			9b. CITY, TOW	OR LOCA	TION OF D	EATH .		TY OF DE	ÅTH
9	Northwest Hospi	tal			Ra	ndal	lst	OLID	Dal	Ltimo	
RECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			the CITY				JW11	- Ba	Y	
1 - N											LIMITS?
	Md. Bal	timore		<u>r</u>	A/V	iof, ZIP CO	OF		10a CITI		1 YES 2 W NO
FUNERAL	645 Northbend R	a							109. 011.	LEN OF W	IAI GOORINI)
3		12. WAS DECEDENT E			13. WAS D	2.1.2 ECENDENT		NIC ORIGIN? (Specify Ye	or No—	14. HACE	American Indian.
	1 Never Married 2 Married	FORCES? 1 []		0			ben, Mexica O Specif	n, Puerto Rican, atc.)		Black, Specify	White, etc.
) BY	3 Widowed 4 Divorced										White
1	15. DECEDENT'S EDUCA (Specify only highest grade of		(GI	ve kind of w	USUAL OCCUPA work done during		king	16b. KIND OF BU	SINESS/IND	USTRY	
1 =	Elementary/Secondary (0-12)	College (1-4 or 5 +)		Do NOT us							
OMPLETED	1 1 17. FATHER'S NAME (First, Middle, Last)	0		are	giver	40.00	THEOLO MA	HOME ME (First, Middle, Meiden		e	
at once	Harold	So	amen			2.5			knowr	,	
	19a. INFORMANT'S NAME (Type/Print)	560		MAILINO	ADDRESS (Street		ildr	Route Number, City or Tow			
티	Thomas Thornhi	11	-		West M						
examiner must be notified	20e. METHOD OF DISPOSITION		20b. PLACEA	ND DATE C	F DISPOSITION		3 rey		CATION -	City or Tow	ZONA n, Stata
Ē	1 Buriel 2 Cremation 3 Remon	val from Stata	Meade	natory or of	dae Ma	a m	Dark	10-14 E			
- E	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A		7.00 1	22. NAME	AND ADDR	ESS OF FA	CILITY	1811	uye,	MICI
Бхап	+ 9 Ath (een)	1100/	//		Dav	id J	. We	eber Fune	ral	Home	
medical	23. PART I. Enter the diseases, or co	emplications that co	aused the de	nth. Do n	ot enter the n	node of d	mond	h as cardiac or reap	Ra I	to.	Md 21229
Ē	ahock, or heart failure. Li iMMEDIATE CAUSE (Fine)	et only one cause	on each line.						•	,	Interval Between Onset and Death
E .		Mass	1215	ER	FORM	lasc	111.0	IR Acci	200	.~	2
event,	a.	DUE TO (OF	AS A CONSEC	UENCE OF): T 13170	1127	-DL	IIX IACC	UEI	7.	A WIEED
	Sequentially list conditions.	BILAT	ERAL	P	VEUM	ONI	B				6 DAYS
ATION	If any, leading to immediate	DUE TO (OF	AS A CONSEC	UENCE OF	7:						
	CAUSE (Disease or Injury c.	DUE TO JOS	AS A CONSEC	HENOE OF							
CERTIFICATION	thet initiated events resulting in death) LAST	002 10 (04	AS A CONSEC	UENCE OF);						
CEH C	d.										
AL CE	PART II. Other significent conditions	contributing to de	eth but not re	eauiting i	n the underly	ng ceuse	given in	Part i. 24a. WAS AN			VERE AUTOPSY FINDINGS
shows any : MEDIC.	O Congutive Car	deymyst.	alty 6	20	Syabete	1 m	ellel	I YES		(MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M M	Br Prediction Car	chravans	halus	as	adent				^		YES 2 NO
AN:	DID TOBACCO USE CONTRI	BUTE TO CAUS	SE OF DEAT	TH YE	S NO	□ UN	CERTAII	N 🗆		0.1	
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	E OF DEAT	H (Check only on OTHER:	n)					
YSI	1 TES 2 NO	Inpetient 2 - Ef			4 - Nursing Ho	me 5 🗆 1	Residence	6 🗆 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJ (Month, Day,		26b. TIME INJ	URY V	JURY AT		26d. DESCRIBE HOW I	NJURY OCC	URED	
	2 Accident investigation	26a. PLACE OF IN	LIUDY			YES 2	∐ NO				
TED 28	3 Suicide 6 Could not be 4 Homicide determined	building, etc.	(Specify)	ne, rarm, s	areet, rectory, on	ice		28t. LOCATION (Street : City or Town, State)	and Number	or Rural Ro	ute Number,
	29a. CERTIFIER					-				_	
29e. CERTIFIER (Check only one) 29m. SIGNATURE ANDITITE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (More)											
8 8		On the Gase of Szam	MINIOTO BINDOT II	westigation	n, in my opinion,				d due to the	cause(a)	and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	alls no	•			29c. LI	CENSE NUI	WEER	29d. DATE	SIGNED (A	Month, Day, Year)
<u>₽</u>	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLSE	DE DEATH STEE	27) /5	Print1	D	411	410	0	ct, 11	h 45
	JOGINDER P ME	HTA NO				AL C	ENT	TER RAND	All <	TIDALI	71133.
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE				- / \	THIS C	11117	1407/	1110
	OCT 1 3 1995	ga columbia	Market								



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the hospital or attending physician. use as the be detached for page 5 should Раде 6 тау be funeral director, ours after death. removal. in by ŏ cremation, burial. and 2 attending physician the atter signed by the 6 has b. Dept. with this After DIRECTOR: Nours after of FUNERAL within 72 I TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: 11

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RALPH TAYLOR TODD SEPTEMBER 24. 1995 0720 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 X M 2 | F 267-16-7369 06-28-1918 9e. FACILITY NAME (If not inetitution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR KENT AND QUENN ANNE'S HOSPITAL CHESTERTOWN KENT Pages 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY DELAWARE KENT XXYES 2 NO DOVER permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit **5026 BAYSIDE DRIVE** 19901 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
H was anecify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Ri 1 YES 2 NO Specify: 1 Never Married 2 Married 1941-1945 BY 3 X Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 10 00 MECHANID AUTO AND MECHINES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) PLINEY TODD BE NELLIE TAYLOR notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 DELORIS JOHNSON (STEP-DAUGHTER) 5026 BAYSIDE DRIVE, DOVER, DELAWARE 19901 9 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20e. METHOD OF DISPOSITION

1 X Buriel 2 Cremation 3 Removal from State DATE 20c. LOCATION - City or Town, State must SHARON HILLS MEMORIAL PARK 9-28-1995 Donetion 5 - Other (Specify) _ DOVER, DELAWARE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TRADER FUNERAL HOME INC. homas 12 LOTUS STREET, DOVER, DELAWARE 19901 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Interval Batween Onset and Death IMMEDIATE CAUSE (Finel disease or condition event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury . Enter UNDERLYING other ! that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY WAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Paskab PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only sons) certificate I the State EXAMINERY HOSPITAL: OTHER: tient 2 | EB/Outsuttent 3 | DOA 27. MANNEY OF DEATH 28s. DATE OF INJURY (Month, Can. War) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Distural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY --- At home, farm, 281. LOCATION (Street and Number or Rural Route Number .00 6 Could not be COMPLETED 28 ltem. 29e. CERTIFIER
(Chark only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner es stated. 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occured at the time, date and place, 796. SIGNO RE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 2 PERSON WHO COMPLETES

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THE TARMS SCAT-MS-90.

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		1. DECEDENT'S NAME (First, Middle, Lest) JOSEPH ANTHONY	VONTRA	N	2. DATE OF DEATH MONTH	10, 1995	3.42 A
should		4. SOCIAL SECURITY NUMBER 3.12 .28 .2.198 1 M 2 F 6. AGE (In yrs. lei 90. FACILITY NAME (If not institution, give street and number)	YRS. MONTHS DAY	AR IF UNDER 24 HRS. //S HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Coun	RYLAHO
2, 3 sho	ECTOR	BAY VIEW MEDICAL CENT		LTIMONI		NI	A
nit. Pages 1,	DIR	M.D. 10b. COUNTY	BALT	IMONES			10d. INSIDE CITY LIMITS? 1 YES 2 NO
ansit permit.	ERAL	1229 S. CLINTON STR	EET	21224	L	USA	WHAT COUNTRY?
the bunal-transit	BY FUN	11. MARITAL STATUS 1 Nover Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 N YES 2 IF YES, GIVE WAR OR DATES	RMEO 13. WAS If yet 1	DECENDENT OF HISPAN I, specify Cuben, Mexica YES 2 NO Specify	n, Puerto Ricen, etc.)	e or No 14. RAC Bla Spe	CE — American Indian, ck, White, atc.
ned for use as	PLETED	(Specify only highest grade completed) (C Elementary/Secondary (0-12) College (1-4 or 5 +)	ECEDENT'S USUAL OCCUP Give kind of work done during b. Do NOT use retired.) BUTCHE	g most of working		SINESS/INDUSTRY	EAT CO.
be detached at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) JOSEPH P. VONTRA	N	18. MOTHER'S NA	ME (First, Middle, Maide)	LONG-	
e 5 should notified	TO B		th. MAILING ADDRESS (Str 4429 N	eet and Number or Rural I			mo-2123
director, page or must be		4 Bundal 9 Commettee 9 Dumanul form State	and DATE OF DISPOSITION ematory or other plece)	CEM. 10	-13.95 1	EAST WO	
e funeral		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Autor D. Seil	CH	E AND ADDRESS OF FA	5.2014		
or other traumatic event, the medic	CERTIFICATION	1	Am 1 thmi DUENCE OF):	1-	-	Hrstory srrest,	Approximats interval Batweel Onset and Dast
as been signed by the att Dept. of Health and Menta 23 shows any Injury,	MEDICAL	PART II. Other significant conditions contributing to death but not Arrival Fibrally from the family DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	al Vascal	v ideak	1 TYES	PRMED?	Ib. WERE AUTOPSY FINDINGS AMPLABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
or Item 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 D ND 26. PLA HOSPITAL: 1 Inpetient 2XX ER/Outpetient	CE OF DEATH (Check only OTHER: UNITED Nursing	Home 5 to Residence	6 Other (Specify)		
frer this ce eath with t marked,	ву РНУ	27. MANNES OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	INJURY M 1	INJURY AT WORK? YES 2 NO	26d. DESCRIBE HOW 261. LOCATION (Street		/ Route Number.
DIRECTOR: A hours after d ltem 28 is	ETED	4 Homicide determined building, atc. (Specify)		=	City or Town, Stuff		
1 -1 m	COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, do not not not not not not not not not no					e(s) and manner as stated.
TO THE FUNERA DE filed within 7.	8	296. SIGNADOTHE AND TITLED OF DESTREES AND TITLED OF TITLED OF DESTREES AND TITLED OF DESTREES AND TITLED OF DESTREES AND TITLED OF TITL		D212	908	29d, DATE SIGNE	ED (Month, Day, Year)
<	10	David Schart M.D.	5. High	land Are	- B= 17	- MD	21224
, -		31. DATE FILED (Month. Day, Year) OCT 1 3 1995 And Churchen Churc				,	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reftained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burfal, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
--	---	--	--

TO BE COMPLETED BY FUNERAL DIRECTOR

	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN	-				
- i	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
ä	Laura Sue	V	anDres	S		Oct. 10,	1995	7:45A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (III	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH	0.0	HETHEL ACE (State or Foreign			
	215-72-6066 9a. FACILITY NAME (If not institution, give stree		8 YRS.	9b. CITY, TOWN	OR LOCATION OF DE		967Was	shington, DC			
<u>۳</u>	Manor Care Nurs:			Larg				ce George			
5	RESIDENCE OF DECEDENT										
DIRECTOR	MD Calver			r, TOWN OR LOC	rederic	le.		10d. INSIDE CITY LIMITS?			
	MD Calve		PI		M. ZIP CODE	K.		YES 2 NO			
RA	302 Deam Avenue				20678		USA	OF WHAT COUNTRY?			
FUNERAL		12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Yes		RACE - American Indian.			
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, s		in, Puarto Rican, etc.)		Black, Whife, etc.			
BY	3 Widowed 4 Divorced			1	S L XIO Specifi	,		White			
COMPLETED	t5. DECEDENT'S EDUCA' (Specify only highest grade co		16a. DECEDENT'S (Give kind of a	vork done during n	ION lost of working	16b. KIND OF BU	SINESS/INDUST	RY			
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Manage			COMPI	utor S	ales			
M	12 17. FATHER'S NAME (First, Middle, Last)	4	Hamage					4200			
8	James E. Butland	d Jr.			Betty	ME (First, Middle, Malden L. Bell	Surname)				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Tow	n State Zin Cori	(e)			
2	John Michael Van	nDress	302 D	eam Av	enue, P	rince Fre	ederic	k,MD 20678			
	20a. METHOD OF DISPOSITION		PLACE AND DATE			DAYE 20c. LO	CATION — City	or Town, State			
	1 Burial 2 Gremation 3 Remove 4 Donation 5 Other (Specify)	il from State Come	etro Cr	emator	У	10/13 Ba	altimo	ore, MD			
	21. SIGNATURE OF EUNERAL SERVICE LICEN	este.			AND ADDRESS OF FA						
	Dahek 1	prodet 1				uneral Ho					
	23. PART I. Enter the diseases, or co	mplications that caused	the death. Do	not enter the m	ode of dying, suc	th as cardiac or resp	iratory arrest,				
	ahock, pr haart fallura. Li:	st only one cause on as	ich lina.					intarval Between Onset and Daath			
	disease or condition reaulting in death)	ENCE	PHAL	DOPAT	LHT.			> one-Mon			
	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions, To HERPES SIMPLEX										
Ĕ	DUE TO (OR ÀS A CONSCOUENCE OF): AQUIR ED IMMUNO DEFICIENCY Synd > 0w-Y. CAUSE (Disease or injury)										
SE	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	Pi:	10 DE	FICIE	000	That Sam I			
CERTIFICATION	reaulting in death) LAST						,				
	0.				-1-1-1						
AL.	PART II. Other significant conditions		ut not reaulting	in tha underlyi	ng cause given in	Part i. 24s. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
9	Decube	aller.	CA D	(.70)	DAI	1 D YES :	2 00	OF DEATH?			
M	DID TODA (CO LIST COLUTTO		800	W C	50.00		/	1 TES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI		F DEATH YI 26. PLACE OF DEA		ZP UNCERTAL	иПТ					
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:							
4	1 YES 2 YOU	1 Inpetient 2 ER/Outp 28a, DATE OF INJURY	28b. TIN	/ -	me 5 Residence	6 Other (Specify) 26d, DESCRIBE HOW	INJURY OCCUR	FD			
	1 Pending	(Month, Day, Year)	IN.	JURY V	ORK?						
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	26e. PLACE OF INJURY	- At home, farm,			281, LOCATION (Street		Tural Route Number,			
뎶	4 Homicide determined	building, atc. (Spec	ify)			City or Town, State)				
٦	29e. CERTIFIER 1 GERTIFYING PHYSICI	AN: To the best of my know	ledge, death occurr	ed at the time, de	te end pleca, end due	to the cause(s) and ma	inner as stated.				
COMPLET								use(a) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER	0	1 NO 0V	2	29c. LICENSE NU	MBER	29d. DATE SI	GNED (Month, Day, Year)			
) BE	S.J-RAO, MD	8	(2000)	200	D-34	525	10	-11-95			
5	30. NAME AND ADDRESS OF PERSON WHO	COMPRETED CAUSE OF DE		ed:	220.	Bori	70-1	WD-20716.			
	31. DATE CILED Monty 1995 Ju	1320 testant for	July 1								
	()										

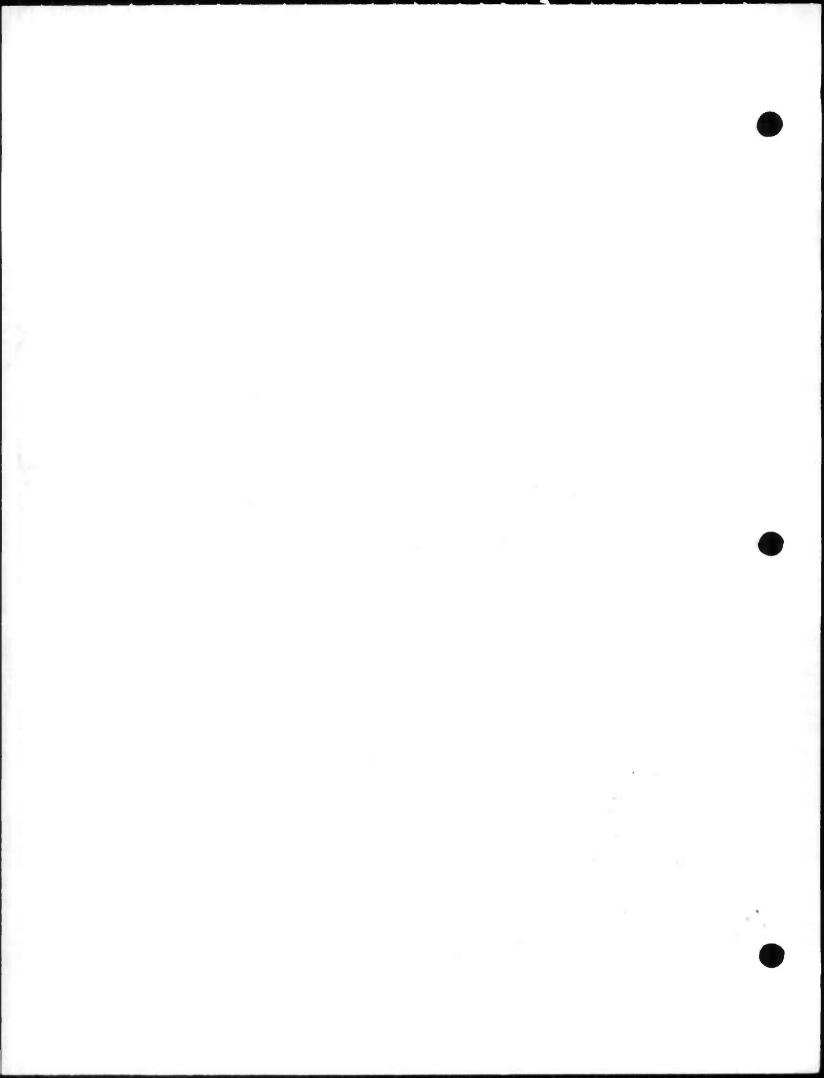
BALTIMORE, MARYLAND 21215-0020

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after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should moval.	ical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	
TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	10 HE FUNEMAL UNECTURE. After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	25 29 29 29 29 29 29 29 29 29 29 29 29 29

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTA	L HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Lest,	/				2. DATE	OF CEATN		rean	3. TIME OF DEATH	P	
	ERIC //	OMBLE 5. SEX B. AGE			OCTOBER 10 1995			95	22	M		
	217-70-1136	1 M 2 F	MC	FUNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTN		Country		ign	
	9e. FACILITY NAME (If not institution, give	21	30	L CITY TOWN (PR LOCATION OF C		6, 195	9c. COUNT		cyland		
DIRECTOR	Manor Care of Ru				n/a					timore		
E	10a. STATE 10b. COUN	ry	10c. CITY, T	OWN OR LOCAT	ION					10d. INSIDE CITY LIMITS?		
		n/a	Bal	timore						1X YES 2 N	0	
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?		
W	5303 Haddon Avent	12. WAS DECEOENT EVER I	110 10150		21207				US			
BY FU	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DO 1975 — 19	2 NO ATES	If yes, sp	ENCENT OF HISPA Holfy Cuben, Mexic 2 X NO Speci	an, Puerto		or No.— 14	Black, Specify	- American Indian White, atc.	la .	
	15. DECEDENT'S EDI (Specify only highest grad	UCATION	16e. DECEOENT'S US	UAL OCCUPATION	DN .	166	. KINO OF BUSI	NESS/INOUS	TRY	DIACK		
۱.	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use n	k done during mo etired.)	st of working							
₫		3 years	Lab	orer		De	ept Pub	lic W	ork	s-Balto	lity	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S N	AME (First,	Middle, Maiden S	umame)				
BE	Ernest Benjamin V	Vomble					L. Wes					
[]	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural							
	Angela Lewis		2810 Oal							d 21215)	
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ren 4 Donetion 5 Other (Special)	noval from State 20b	PLACE AND DATE OF D Belefy, cremetory or other ETO Crema	DISPOSITION (Na	me of	OCPET		ATION — CIT				
	21. SIGNATURE OF FUNERAL SERVICE L		ecto crem		D ADDRESS OF F	ACH ITYATa	11 Cat	onsvi	lle	, MD omes, In		
	· Comet K.	TEmy-		Baltin	wynns r nore, Ma	aııs rylar	Parkwa nd 212	у 16		omes, In	ic.	
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final	. List only one ceuse on e	ech line.		de of dying, au	ch aa care	diac or reapire	itory arrea	t,	Approximate interval Bets	ween	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) A DUE TO (OR AS A CONSEQUENCE OF):										Peatri	
_	Alisholic (11/608)S											
CATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
	cause. Enter UNDERLYING CAUSE (Disease or Injury	C										
ERTIF	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):									
E	Commission County Excel	d										
ا پ	PART II. Other aignificant condition	ns contributing to deeth b	ut not resulting in t	he underlying	ceuse given in	Part I.	24a. WAS AN A	UTOPSY	24b. 1	WERE AUTOPSY FIND	WNGS	
3							PERFORM			AVAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?		
MEDIC							,			1 YES 2 NO	,	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAI	NZ						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATN (Check only one) THER:								
PHYSICIAN:	1 TYES 2 NAO	1 Inpetient 2 ER/Outp			5 🗆 Reeldence	6 🗆 Othe	r (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME O	WO	RK?	28d. DES	CRIBE HOW IN.	URY OCCUP	ED			
à l	2 Accident Investigation				ES 2 NO							
ETED	3 Suicide 8 Could not be 4 Nomicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, stree	et, lectory, office		28f. LOC City	ATION (Street en or Town, State)	d Number or	Rural Ro	ute Number,		
COMPL		BICIAN: To the beat of my knowl ER: On the basis of exemination							2U20(0)	end menner ee stat-	ed.	
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NU					Month, Day, Year)	-	
	Bonnel Cil	can me			1417	97				B/95		
2	30. NAME AND ADDRESS OF PERSON WI	_	ATH (ITEM 27) (Type, Prin	nt)	.,	. /		-		- 3		
	31. DATE FILED (Marth, Day, Year)		TURE									
	31. DATE FILE (13 1995)	32. REGISTRAR'S SIGN	II.									





8. BIRTHPLACE (State or Foreign

n/a

10g, CITIZEN OF WHAT COUNTRY?

21217

Balto., MD

USA

14. RACE — American Indian, Black, White, etc.

Specify: Black

Interval Batween

Onaet and Death

AVAILABLE PRIOR TO

1 TYES 2 1 NO

29d. DATE SIGNED (Month, Day, Year)

Dot. 11

Medier Levez

COMPLETION OF CAUSE

10d, INSIDE CITY LIMITS?

1 XXES 2 NO

3:00 PM

YEAR 95

9c. COUNTY OF DEATH

1923

2. DATE OF DEATH

october

1 - STATE

1. DECEDENT'S NAME (First, Middle, Last)

丁巨ムム1月

A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS NOURS MIN. 227-14-6223 1×M20F 72 YRS. Feb. 21, 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Liberty Medical Center Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION MD Baltimore n/a permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1536 McKean Ave. 21217 burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify. 11. MARITAL STATUS 1 Never Married 2 XX XX arried BY 3 Widowed 4 Divorced the hospital or attending WW use as t COMPLETED 15. DECEOENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUSTRY (Specify only highest grade completed) (Give kind of work done during m life. Do NOT use retired.) College (1-4 or 5+) Por Elementary/Secondary (0-12) Maritime Merchant Seaman once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) retained by the John Winfield Julia Rivers 200 To page 5 should notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Burel Boute Number City or Town, State, Zin Code) 2 Hester b. Winfield 1536 McKean Ave. Balto., MD 90 pe 20s. METHOD OF DISPOSITION
COMMITTED 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Page 6 may must Arbutus Memorial Park 10/16 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home 23. PART i. Ehler the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or haart failure. Liet only one cause on each line. 1701 Laurens St. Balto., Md medical 3 filled in 1 IMMEDIATE CAUSE (Final the disease or condition and completely file burial, cremation PNUEMONIA with SEPSIS reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): LEREBROYASLULAR ALLIDENT ALUTE traumatic CERTIFICATION Sequantially list conditions, DUE TO 100 AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to FAILURE. RENAL CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL law requires that the and PERFORMED? - METASTATIL PRUSTATIC CANLER signed b 1 YES 2 NO shows a - DIABETES MELLITUS been N. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Item 2 The s certificate t HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) OR ATTENDING PHYSICIAN: 1 TYES 2 NO 10 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY death with the search of the search 26d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation BY Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be DIRECTOR: A hours after d Item 28 is 4 Homicide determined Item 29a. CERTIFIER (Check only one)

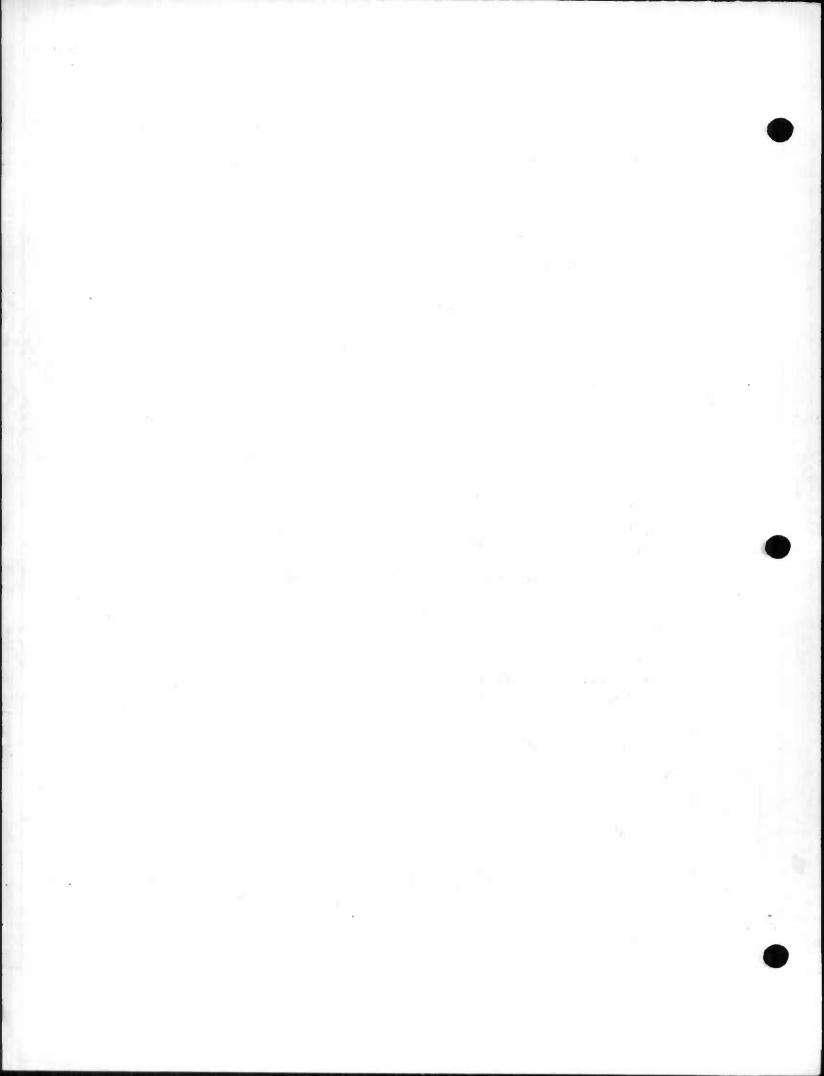
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL ID THE FUNERAL ID THE FUNERAL ID THE FUNERAL IT IN IMPORTANT: If I HOSPITAL ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE MD. D 23300 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Liverty M SUDMIR. D. PATEL. 2600 diberty Rd.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

WINFIELD

DHMH-16 Rev 1/89



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VSICIAN: The law requires that the death certificate be executed withing 14 hours with the first bear of many be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the function described for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removed.	or item 23 chaus any injury or other traumatic event the made a second and an existence of the second
天	this certificate with the State	rked or item
A ATTENDING F	IERAL DIRECTOR: After in 72 hours after death	m 28 is mar
TO THE HOSPITAL OR ATTENDING I	TO THE FUNERAL DIRECTOR: After this come filed within 72 hours after death with 1	PORTANT: if item 28 is marked
2	5 9	MP

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPAR	TMENT OF H	EALTH AND	MENTA	L HYGIEN	E		
8	1. DECEDENT'S NAME (First, Middle, Last)		WILL			MON	E OF DEATH		EAR 3	4:57 pm M
	4. SOCIAL SECURITY NUMBER 5 070-58-7/53 1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. less 0 70 -58 - 7/53 1 № № 2 □ F 30				7. DATE	7. DATE OF BIRTH (Month, Day, Year) Cour (Month, Day, Year) BA			ACE (State or Foreign OKLYW N.Y
POR	9a. FACILITY NAME (If not institution, give stree Saint Joseph Medica				on, Mary			9c. COUNTY	OF DEA	
AAL DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10a. STREET AND NUMBER			BALT: MORE 101, ZIP CODE 109, CITIZEN					1	od. INSIDE CITY LIMITS? YES 2 NO AT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	LAFA VETTE N. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N IF YES, OIVE WAR OR DATES	MED	13. WAS DEC	2/2/ ENDENT OF HISPA polity Cuban, Maxic 2 XNO Speci	NIC ORIGI	N7 (Specify Yes Rican, etc.)	or No- 14.	RACE Black, 1 Specify:	- American Indian, White, atc.
COMPLETED	12		CEDENT'S I we kind of we Do NOT use	USUAL OCCUPATION ork done during most retired.) NE	N at of working	16	LON,		TRY	
BE CO		LTER SR.			18. MOTHER'S NA	ME (First,	Middle, Melden . SiNG	Sumame)	U	
10	194. INFORMANT'S NAME (Type/Print) MAN BROWN		370 (CHAUN	nd Number or Rural	- #C	H BROW	o, Stata, Zip Co	do)) , /	O. Y. 1/233
	20a. METHOD OP DISPOSITION 1 Burlal 2 Cremation 3 Remova 4 Donetion 5 Other (Specify) 21. SIGNATURE OF AUHERAL SERVICE LICESE	from State complete, cred	natory or oth		D ADDRESS OF FA	7.8,/	795 M	ORGA	Or Town	Stora N.J
	Thomas J.	Starde Ja	ģ	SKA	CDA FI	4-	BAU	0,	MD	. 21224
	23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, above, or heart failure. Liet only one cause on each line. Approximate interval Between Onset and Death disease or condition resulting in death) SEVERE HYPOXEMIA									
Z	PRIMARY PULMONARY HYPERTENSION									9 MONTH
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): RIGHT HEART FAILURE C. DUE TO (OR AS A CONSEQUENCE OF): AIDS									9 MONTH
MEDICAL CE	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. KAPOSI'S SARCOMA 24a. WAS AN AUTOPSY PERFORMED? AND SECONDARY 1 D YES OF NO.						ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								YES 2/5,NO	
PHYSICIAN:	EXAMINER?	OSPITAL: Nopatient 2 ER/Outpatient 3		OTHER: United the House of the	5 🗆 Residence	6 🗆 Oth	er (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO		28d. DE	SCRIBE HOW IN	JURY OCCUR	ED	
ETED	3 Suicide 6 Could not be 4 Homicide detarmined	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number,								
COMPLE		N: To the best of my knowledge, dea on the besis of exemination and/or in							luse(s) a	nd menner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	J. Hush	2	Cae	29c. LICENSE NUI D36814			29d. DATE SI	GNED /M	lgrith, day, Your)
	30. NAME AND ADDRESS OF PERSON WHO C RICHARD L. HUSLIG	ND ST JOSEPH N			R,TOWS	MAC	ARYLAN	D 21204		
	OCT 1 3 1995	32 REGISTRAR'S SIGNATURE							-	

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			4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7.
	77		178-32-5368	5	1 XM 2 F	53	YRS.	MONTHS	DAYS	HOURS	MIN.	1
	should		9a. FACILITY NAME (If not in	stitution, give s	street end number)			9b. CITY, T	OWN (OR LOCATI	ON OF I	DEATN
	(C)	S.	Laurel Regi	onal t	Iospital			Laur	el			
	1, 2,	DIRECTOR	RESIDENCE OF DEC									
	ages	뿐	10e. STATE	10b. COUNT	Υ			Y, TOWN OR		ION		
	护	_	Virginia				Ri	chmon	d_			
	Deci	A	100. STREET AND NUMBER						101	ZIP COD	E	
ë	ansit	5	114 West 34	th Str	ieet					2322	4	
020 physician.	burial-transit permit. Pages 1,	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN					ENDENT C		
00 g	Ď.	BY F	1 Never Married 2 3 Widowed 4 X Divo		IF YES, GIVE		2 X NO			ecity Cube 2 NO	in, Mexic Spec	
	as the											
121 affe	nse	COMPLETED		EDENT'S EDU y highest grade		10	6a. DECEDENT'S (Give kind of a	work done du	UPATIO	oN st of worldr	10	
	Ď.	Ë	Elementary/Secondary (0)-12)	College (1-4 or 5		Ille. Do NOT us					
AND 2	detached once.	M			1		Telemar	Recer				
₹ 2		응	17. FATNER'S NAME (First, M	liddle, Last)						18. MOT	NER'S N	IAME (
2 ×	d at o	BE	Wayne Bell									
MARYL retained by t	should	0	19a, INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRESS (Street e	nd Number	or Rura	/ Aoute
413	age 5 should be be notified at	-	Wayne Bell									
BALTIMORE, er death. Page 6 may be	director, page er must be		20a. METNOD OF DISPOSITI		oval from State	20b. PL	LACEANDDATE	OF DISPOSITI	ON/Na	ma of		
0 9	must		4 Donation 5 Other	(Specify), VI	state ne	mdyal.	ery, crematory or o	ther place)				
Fage .	d in by the funeral dir or removal. medical examiner		21. SIGNATURE DE FUNERA	L SERVICE LIC	censee Gonal	d wad	e, vir.	22.74	MEAN	Appre	SE OF F	ACILIZ
ALT death.	funeral xamin		Buran.	111	11/20.			Dm	P	026-	Ral	y 13
	by the removal.	-	23. PART I. Enter the di	1//1	complications the	t named at	and the first					
d in by or rem		- 1	ehock, Dr h	eert fellure.	Liet only one ceu	ise on eecl	ne deetn. Do n h iine.	ot enter th	ie mo	de of dy	ng, su	ch aa
		- 1	IMMEDIATE CAUSE (Fir disease or condition	nai	^		1 - 5-				A A.	5 /
4			resulting in death)	→	. Acu	TE	AM	ER	D		100	Y C
76(w	completely ial, cremati event, t				DUE TO	(OR AS A C	ONSEQUENCE OF	F):				
(68760 executed with	등 절 등	Z	Sequentially list conditi	Inne	b							
	or to	Ĕ	If any, leading to imme-	diate	DUE TO	(OR AS A CO	ONSEQUENCE OF	F):				
BOX	physician ne prior to ler traum	2	cause. Enter UNDERLYI CAUSE (Disease or Inju		с.							
	of die	E	that initieted events resulting in death) LAS	_	DUE TO	(OR AS A CO	ONSEQUENCE OF	F):				
□ €	attending ntal Hygie y, or off	CERTIFICATION	Tooling III deathy EAD		d							
	as been signed by the attending philepolic of Health and Mental Hygiene 23 shows any injury, or other		PART II. Other eignifice	nt condition	s contributing to	deeth but	NOT reculting I	n the unde	rlvino	COLUMN C	alven k	n Part
That th	and in	8							,,	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
S E	Health Health	8										
CC 2	t. of Health shows an	CIAN: MEDICAL	DID TOBACCO U	SE CONT	DIBLITE TO CA	LICE OF	DEATH VE	and w				
- 6		AN	25. WAS CASE REFERRED TO		KIBUTE TO CA			S NO NO		UNC	ERTA	IN L
- E	a a E		EXAMINER?	O MEDICAL	HOSPITAL:	20.	PLACE OF DEAT	OTHER:	y one;			
> SE	cerunca h the St d, or it	PHYS	1 YES 2 NO		1 Inpatient 2			4 🗆 Nursin		_	eldence	8 🗆
OF V	with with	古	27. MANNER OF DEATH	Pending	28s, DATE OF (Month, G	lay, Year)	28b. TIM	URY	WO	JRY AT RK?		28d
Z g	death with	B		investigation	80	A				ES 2] NO	
	00			Could not be	28e. PLACE building,	F INJURY — etc. (Specify)	At home, ferm, s	street, factory	, office			281.
DIVISION DR ATTENDING F	hours after item 28 i		4 Nomicide	datermined								
5 E		COMPLETE	290. CERTIFIER CERT	IFYING PNYSI	CIAN: To the best of	my knowleds	ge, death occurre	d at the time	. date	end place.	end du	e to th
PITA	1 2 2 E	2			R: On the basis of e							
DIVISION OF V	to the Funeral be filed within 72 IMPORTANT: If		29b. SIGNATURE AND TITLE									
품 ;		H	A 1) /	M.	molar	h ~	112			29c. LICE	NSE NU	MBER
2	2 8 €	2	30. NAME AND ADDRESS OF	PERSON WAY	O COMPLETED CAN	DE DE DE DE	A CITER OF C	El-lan		1) 3	5	26
	l	.	ARCIADO	A A	A WILLE	SE UP DEATH				,	^	
	}		31. DATE FILED (Month, Day,	Apar)	MEHTE	T- (1		3 alf	7 0	nose	1-	100
	0	Ì	OCT 1	3 1005	Felia a	AUCULON'	Kardall					
	- 1		44.7	The state of	1/							

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

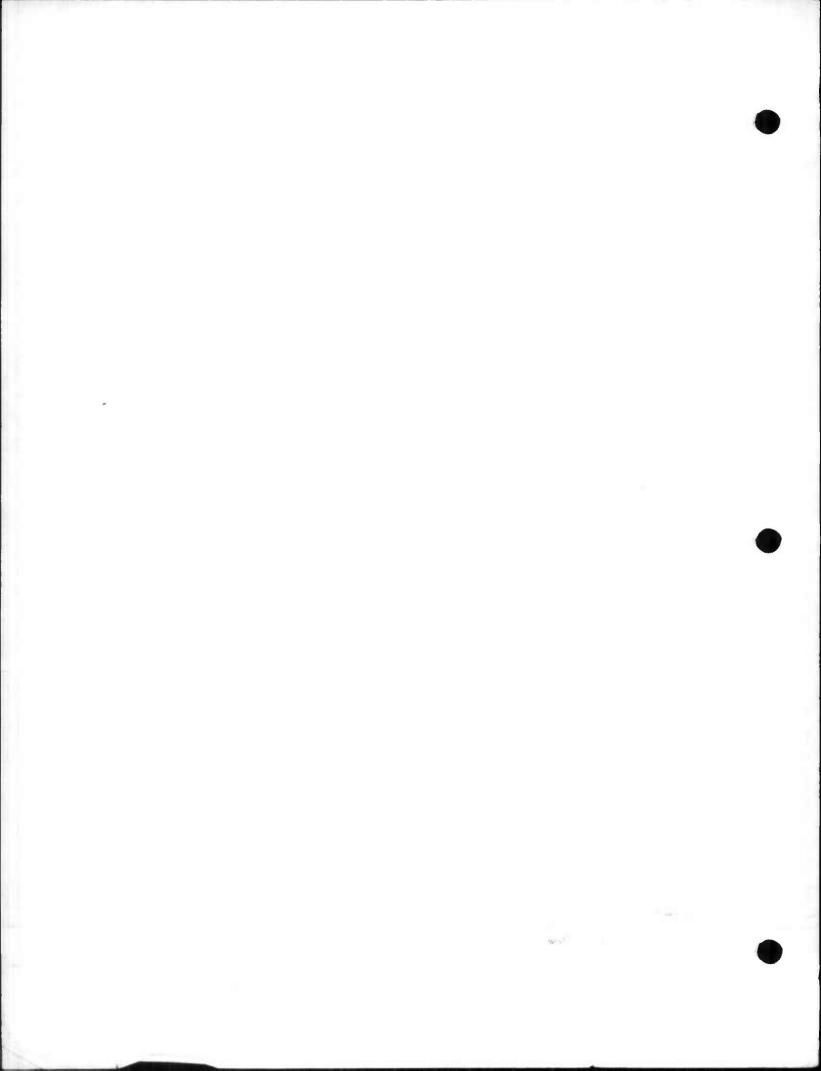
WILSON

RICIL

95 31013 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 3. TIME OF DEATN 9=58A 95 7. DATE OF BIRTN (Month, Day, Year) B. BIRTNPLACE (State or Foreign Country) IF UNDER 24 HRS. HOURS MIN. 10-19-41 Ponnsylvania
9c. COUNTY OF DEATH R LOCATION OF DEATH Prince George's ON 10d. INSIDE CITY 1 YES 2 NO ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 23224 U.S.A. ENDENT OF NISPANIC ORIGIN? (Specify Yee or No— lefty Cuben, Mexicen, Puerto Ricen, etc.) 2 NO Specify: 14. RACE — American Indian, Black, White, etc. specify: White of working 16b. KIND OF BUSINESS/INDUSTRY Sales 18. MOTNER'S NAME (First, Middle, Maiden Surname) nd Number or Rural Route Number, City or Town, State, Zip Code) na of DATE 20c. LOCATION — City or Town, State Anatomy Board-655 W. Baltimore Street 026-Baltimore, Maryland 21201-1559 le of dying, such as cardiec or reepiretory arrest, Approximata Interval Batween Onset and Death Z MYOCARDIAL INFORMATION DAYS 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ceuee given in Part I. 1 YES 2 NO 1 YES 2 NO UNCERTAIN 5 Residence 8 Other (Specify) RY AT 28d. DESCRIBE NOW INJURY OCCURED ES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) nd place, end due to the cause(e) end menner ee stated. ith occured at the time, date end place, end due to the ceuse(s) end manner ee stated,

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29d. DATE SIGNED (Month.



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DIRECTOR; After the hours after death v

FUNERAL Within 72 h

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 AEGISTRAS SIGNATURES

Beriagin H. Trichon.

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FilmG, 728, item #10g, 10/16/95,cyw, per f.h.
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ,1995 TYRONE BERRY OCTOBER 13 5:24 a 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. CAMARYLAND. 1959 36 218-78-7625 1 XXM 2 | F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10c. CITY TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1 XES 2 NO FUNERAL 10s STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY?
STATES
UNITED STAES 101 ZIP CODE 21213 1661 CLIFTVIEW **AVENUE** 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, atc.)
 T YES 2 NO Specify: 11. MARITAL STATUS 14. RACE - American Indian, Black, Whita, etc. 1 Never Married 2 Married SpecifyBLACK BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 th LABORER various trades once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **FRANCES** Ħ RAYMOND BERRY CUMMINGS BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 AVENUE, **FRANCES** MELVIN 1661 CLIFTVIEW BALTIMORE, MD 21213 be 20a. METHOD OF DISPOSITION
1 X Burial 2 □ Cremation 3 □ Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must KING MEMORIAL **PARK** 10-18 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTHAVENUE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onaet and Death IMMEDIATE CAUSE (Final the disease or condition resulting in desth) Sepsis Iweck event, DUE TO (OR AS A CONSEQUENCE OF): Peritonidis 2 weeks traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Indra- Abdoming) 3 weeks Abrcess CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated avents Relouins reaulting in death) LAST Veor 10 injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any T YES 2 shows a 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only or 25. WAS CASE REFERRED TO MEDICAL Item SFITAL. **EXAMINER** OTHER: 1 YES 2 npetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 28a. DATE OF INJURY (Month, Day, Year) 27 MANNER OF DEATH 28c. INJURY AT WORK? marked, Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 49 3 Suicide COMPLETED 6 Could not be after 28 I 4 Homicide determined tem DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(a) and manner as stated. (Check only one) =WEDI XAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Dehober 13, 1995 1 2

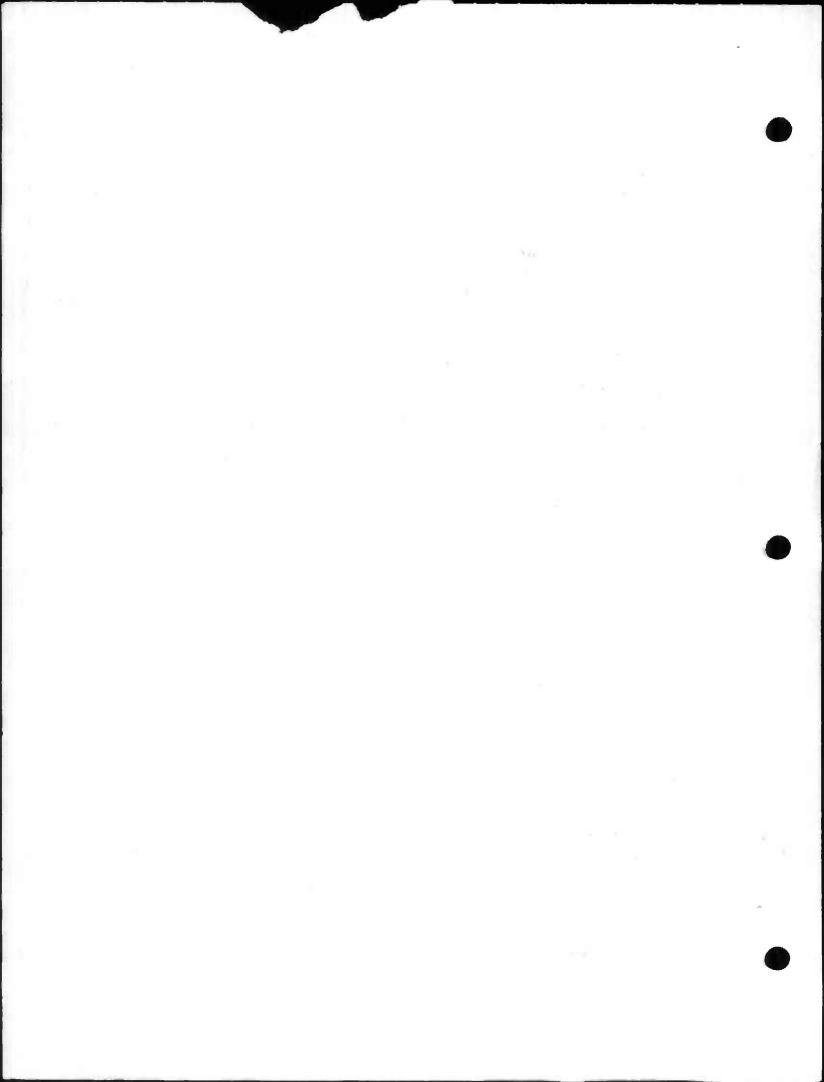
FOR

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	1 - STATE REGISTRAR		CATE OF		REG. N						
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		YEAR 3. TIME OF DEATH				
	Lloyd Samue Bohr	er			OCT. 9		5:30 A M				
	010 06 5716	56 vss	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Sept Day 1507)	1020	8. BIRTHPLACE (State or Foreign Country) W VA				
		OO YRS.									
DIRECTOR	99. FACILITY NAME (If not institution, give street end number) HARBOR HOSPITAL RESIDENCE OF DECEDENT			MORE CI		9c. COUNT	N/A				
E C	10a. STATE 10b. COUNTY	10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY				
	MD BAHO. City	В	altimore	, MD			LIMITS?				
FUNERAL	100. STREET AND NUMBER 2001 Annapolis Rd		101.	21201		10g. CITIZ US.	EN OF WHAT COUNTRY?				
BY FUN	11. MARITAL STATUS 1 X Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR OR	S 2 NO	If yee, spe	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify what no Mexicen, Puario Rican, etc.) 1 YES 2 NO Specify: White, etc.							
2	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECEDENT'S	USUAL OCCUPATIO	N .	16b. KIND OF	BUSINESS/INDU	JSTRY				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +) 10 th	Machine	e retired.)		Carr I	owrey	Co				
	17. FATHER'S NAME (First, Middle, Last)	Hachine	operato.		ME (First, Middle, Meid	-					
BE C	Earl Otis Bohrer			Laura 1	Mae MacDo	nald					
2	19a. INFORMANT'S NAME (Type/Print) Audrey Hite				ltimore, M						
		ob. PLACE AND DATE Of the control of	FDISPOSITION (Name of DATE 20c. LOCATION — City or Town, State er piece) Matory 10-12 Catonsville, MD								
	21 SIGNATURE OF FUNERAL SERVICE LICENSEE			D ADDRESS OF FA	eral Home						
	Dean P Charlton						,MD 21231				
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdisc or respiratory arrest, abock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF): Approximata Interval Between Onaet and Death Onaet and Death DUE TO (OR AS A CONSEQUENCE OF):										
CERIIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										
2	CAUSE (Disease or injury that initiated eventa DUE TO (OR AS	A CONSEQUENCE OF):								
	resulting in death) LAST		_								
	PART II. Other algnificent conditions contributing to deeth	but not reculting is	n the underlying	cauee given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS				
EDICAL	— CHRONIC ALCOHOLISM PRIOR COMPLETION OF 10 OF DEATH?										
2	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YE	S NO [UNCERTAIN	<u> </u>		¹XXES 2 □ NO				
NA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEAT									
	EXAMINEH? 1 ∑YES 2 ☐ NO 1 ☐ Inputient ※XER/OL	utpetient 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Realdence	8 Other (Specify)						
PHYSICIAN: ME	27, MANNER OF DEATH 1X XNstural 5 Pending 28s. DATE OF INJUR' (Month, Day, Year		URY WO	RK?	26d. DESCRIBE HO	W INJURY OCC	URED				
R	2 Accident Investigation 28e PLACE OF INJUI	RY — At home, ferm, s		ES 2 NO	281 LOCATION (Str	of end Number	or Rural Route Number,				
	Suicide 6 Could not be building, etc. (St. 4 Homicide datermined	pecify)			City or Town, St		or realist readily framework				
COMPLEIED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my known one) 2 MEDICAL EXAMINER: On the best of examinet										
ש ה	200. SIGNATURE AND TITLE OR CERTIFIER	20.1		29c. LICENSE NUI			SIGNED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	STATE WITTEN AT A	(Print)	O.C.M	. E	00	CT. 9,1995				
	Donald G. Wright M.D. 1	lll Penn		, Balt	imore,	Maryla	and 21201				
	31. DATE FILEO (Month, Day, World OLD 1 6 1995	NATURE									

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	1 - STATE REGISTRAR	SIAIE UF MANTLA		ICATE OF			REG. NO					
	1. OECEDENT'S NAME (First, Middle, Last)					2.	DATE OF DEATH		YEAR	3. TIME OF DEATH		
	CYNTHIA	M	BELL				10 8		95	11:30 PH		
			yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24	HRS. 7.	DATE OF BIRTH (Month, Day, Year)	-0	Country	PLACE (State or Foreign		
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR	0.10	□M2XF 3	5 YRS.				12/6/3	57	BALT	IMORE, MD		
~	9a. FACILITY NAME (If not institution, give stree			Ob. CITY, TOWN	OR LOCATION	OF DEATH	VII	9c. COL	UNTY OF DE			
0	Bayview Med. Cent	ter		Lau	mor	<u>u</u> _	MI		n/	a		
EC	10e. STATE 10b. COUNTY 10e. C/EY. TOWN OR LOCATION 10d INSIDE C/LTY											
DIE	MO	n/a	15	alun	we					YES 2 NO		
	100. STREET AND NUMBER 6002	Amberwood)	load	10	H, ZIP CODE	212	06	10g. CI1	TIZEN OF V	VHAT COUNTRY?		
B	602 cmwwood Are 2/303 45A											
	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, s	pecify Cuban, I		, Puarto Rican, etc.)			- American Indian, c, White, etc.		
	(Specify only highest grade co.	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 17b. December 19b. KINO OF BUSINESS/INDUSTRY										
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEN	1AKER			in	own	hom	e		
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	R'S NAME	(First, Middle, Maiden					
	JAMES EDWARD	BAILEY			1 3	MA	RY GOUGI	Н				
	19a. INFORMANT'S NAME (Type/Print)						e Number, City or Tox		,			
	MARY JOHNSON/MARY J. BAILEY 2611 E. MADISON STREET, BALTIMORE, MD # 05											
	28s. METHOD OF DEPOSITION 1XXXIIII 2 ☐ Cremetion 3 ☐ Remove	of State on Witnessen and		OF DISPOSITION (A			227 F 200 L		- City or To			
	4 Donation S Donat (Specify) / VUSHELL MEMORIAL GARDENS 10-13 DUNDALK, MD											
	21. SIGNATURE OF PARILETY March F.H E. 1101 E. North Ave.											
	23. PART ENG the diseases, or bor	npilications that caused	the death. Do	not enter the m	ade of dying	, such a	s cerdiec or resp	iratory a	rrest,	Approximate		
FICATION	interval Betwee Onset and Dead											
		DUE TO (OR AS A	CONSEQUENCE O	OF):						10/0/05		
	Sequentially list conditions, Due to ion as a consequence on											
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF: C. DUE TO (OR AS A CONSEQUENCE OF: C. C											
FIG	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	50 11	27 -		2-1-			1		
MEDICAL	resulting in death) LAST	lead	to (100	ront	no	mise			11 11		
	PART II. Other aignificent conditions	contributing to death by										
	TAIT II. Other mightheath conditions	sommoung to deem bu	it not resurting	in the underlyi	ig cause giv	en in Pa	PERFO	RMED?	240	AWAILABLE PRIOR TO COMPLETION OF CAUSE		
	1 VES 2 NO COMPLETION OF OF GEATH?									OF OEATH?		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NOW UNCERTAIN									1 YES 2 NO		
	25. WAS CASE REFERRED TO MEDICAL			ATH (Check only on	-	NIAIIN						
SIC	EXAMINER?	HOSPITAL:	ntlant 3 DOA	OTHER:	me 5 Resid	dence 6	Other (Specify)					
Η	27. MANNER OF DEATH	28a. OATE OF INJURY	28b, TII	ME OF 28c. II	JURY AT		d. OESCRIBE HOW	INJURY O	CCUREO			
	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, reer)	(Month, Day, Year) INJURY M 1			NO						
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Speci	28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)			28t. LOCATION (Street and Number or Rural Route Number,						
TE	4 Homicide detarmined	City of Jown. State										
PLE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	edga, death occur	red at the time, de	ta and place, a	nd dua to	the cause(s) and ma	nner aa si	stated.			
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as											
	296. SIGNATURE AND TITLE OF CERTIFIER	10	(4)	10	29c. LICENS	SE NUMBE	R _	29d. D/	TE SIGNEC	(Month, Day, Jear)		
8	Tourdes O	Ama	0 14	D	D4:	56C	9	•	10	118/91		
Ĭ	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Lipoy Print)											
	1017 Cast	selumn	0 8	/	Ollle	vm	ne	M	/			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA						,				
		MILL dibuttless	0.48-11									



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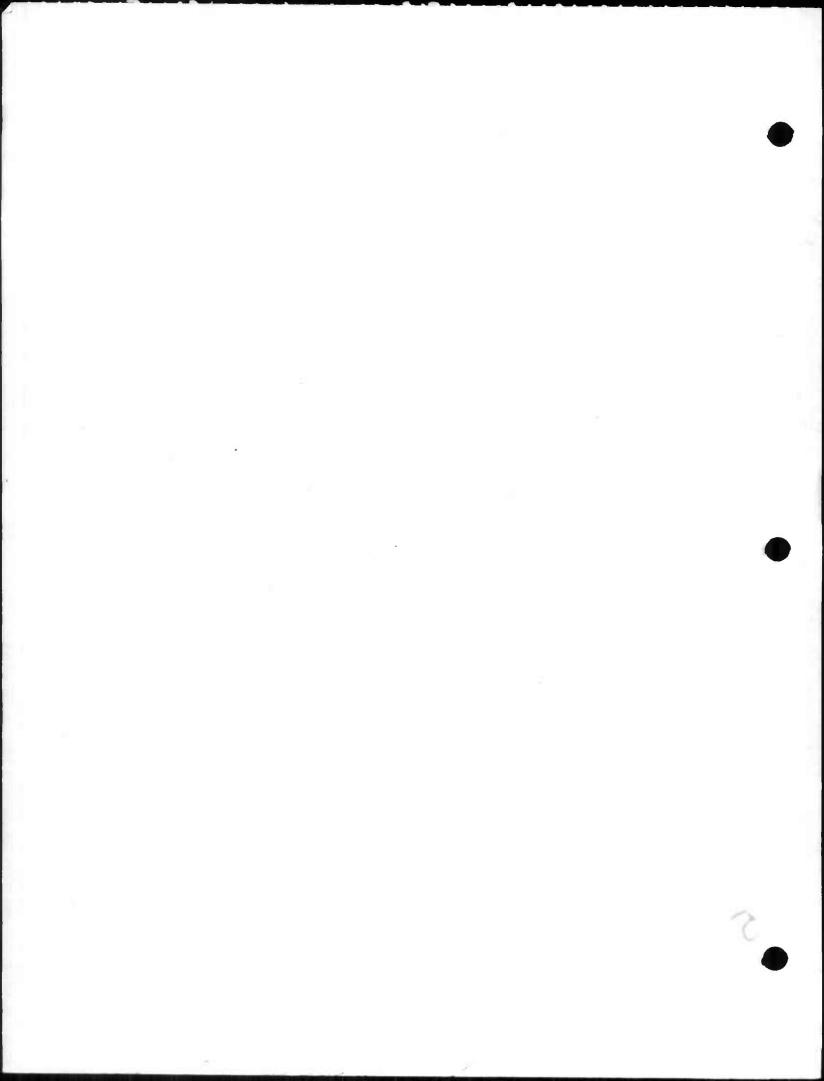
TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ther death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	:8 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certifical		IMPORTANT: If Item 28 is marked, or its

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR 6:30 AM MARY BENTON A. 995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign DAYS HOURS 15 JAN. 3, 1930 214-26-4531 1 M 2 X F MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 901 IRIS AVE NIA DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD BALTIMORE 1 X YES 2 NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 10f. ZIP CODE 901 IRIS U.S. A. AVE 21205 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 □ YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 1 Never Married 2 Married Specify: WHITE IF YES, GIVE WAR OR DATES 8 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) E N/A. AP. PERATOR 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) be notified at EMMA HOGAN BE 19a. INFORMANT'S NAME (Type/Print) 2 Pylesville, Md. HEIL MAN Mas. Mary P. ELPP LAREMONT Mill Rd 20s. METHOD OF DISPOSITION
1 M Burlel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must SKYSVIILE 1016 4 Donation 8 Other (Specify) RESTLAWN EMETERY examiner 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 122. NAME AND ADDRESS OF FACILITY TUNERAL Smoll Rd. BALTO. MG 23. PART/Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7527 medical Approximata Interval Batwee IMMEDIATE CAUSE (Final Onset and Death the disease or condition PARVMONIA HEMOPHILOS FARLUDIZAE
DUE TO (OR AS A CONSEQUÊNCE OF): resulting in death) OBSTRUCTURE PULMONARY DISEBE CHROMIC OBSTEDUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE HORMC STENOSIS 1 TYES 2 NO OF DEATH? CORONARY ARREY DISEASE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES, TO NO UNCERTAIN . 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nome 5 Rasidenca 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dev. Year) 28d, DESCRIBE NOW INJURY OCCURED 28c. INJURY AT WORK? 1 Natural 5 Pending 1 YES 2 NO ВУ Accident Investigation 28a. PLACE OF INJURY — At home, ferm, atrast, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined COMPLETED 4 Nomicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ocroser 12, 1995 2

Tower 10 600 Niverte ST

BARMORE MD



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR	SIAIE UF N		IFICATI				ENIAL	REG. NO.	E					
1. DECEDENT'S NAME (First, Middle, Last)	DENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OEATH								OEATH					
KEVIN	SC	SCOTT		BOBLITZ			OCT. 13, 199			95"	4:55	P. M		
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthda	MONTHS	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year). AUGUST 26,		B. BIRT		PLACE (State	or Foreign		
212-88-0383	1 💢 M 2 🗆 F	36 YRS						t 26,			aryla	nd		
9e. FACILITY NAME (If not institution, give	street and number)			r, TOWN OI					9c. COUN					
4807 E. JOPPA RESIDENCE OF DECEDENT 100. STATE 100. COUNT Maryland Balt	4807 E. JOPPA RD.					PEI	RRY	HALL	Ba:	tim	ore			
10a, STATE 10b. COUNT	Υ	CITY, TOWN	OR LOCATI		•		[-				CITY			
Maryland Balt	timore	Perry	Hal	1					1 YES					
10e. STREET AND NUMBER	T AND NUMBER					101, ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?			
100. STREET AND NUMBER 4807 East Joppa I 11. Marital Status 1 V Never Married 2 Married	Road		21128					U.	S.A	S.A.				
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1		13. WAS DECENDENT OF HISPANIC ORIGIN? (Spi If yes, specify Cubsn, Maxican, Puerto Rican,					or No-	14. RACE Black	ACE — American Indian, Black, White, etc.				
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES					1 YES 2 NO Specify:					Specify: White			
	UCATION 166. DECEDENT'S USUAL OCCUPATION 166. KINO OF BUSINESS						SINESS/IND		nrte					
15. OECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5 -	(Give kind	of work done T use retired.)			g	1000		J	331111				
12	Conage (1-4 of 5)		Ground	l Cab	le S	pecia	alist	·	tilit	y S	ervice	es		
17. FATHER'S NAME (First, Middle, Last)														
Raymond L. Boblit	ZZ				В	essi	e Eil	een L	itz					
198. INFOHMANT'S NAME (Type/Print)		19b. MAIL	ING ADORES				oute Numbe	; City or Tow	n, State, Zip	Code)				
Raymond L. Bobli	tz		Sa	ime a	s 10	е					5			
20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 💢 Cremation 3 ☐ Reit	novel from State	20b. PLACE AND DA	TEOF DISPOS	SITION (Nan	ne of		DATE	20c. LO	CATION —					
4 🗆 Donation 5 🗔 Other (Specify)	4 Donation's Dotter (Specify) Hilltop Service Corporation 10/17/95 Towson , Maryland													
21. SIGNATURE OFFUNERAL SERVICE L	22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc.													
Ineld (K	5305 Harford Road, Baltimore, Maryland 212													
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate District Chyprocodone and Methadone) Intoxication Due to (or as a consequence of): Due to (or as a consequence of):													
	devents DUE TO (DR AS A CONSEQUENCE DF):													
	ns contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTO PERFORMED? YES 2 \(\sum \)							RMED?	AWAILABLE PRIOR TO		PRIOR TO N DF CAUSE			
DID TOBACCO USE CONT	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D	OTHE	, ,										
1 XYES 2 NO	1 Inpetient 2	ER/Outpatient 3 DO	A 4 🗆 Nu		5 XRe	sidence (6 🗆 Other	Specify)						
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 DYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF (Month, D	ay, Year) FOUI	28b. TIME OF 28c. INJURY AT WORK?				28d. DESCRIBE HOW INJURY OCCURED							
2 Accident investigation	10-13-	13-95 2:38 PM 1 TES XX NO					UNKNOWN							
3 Suickde 6 XX Could not be 4 Hornickde determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4807 E. JOPPA ROAD							
29e. CERTIFIER	BALTIMORE COUNTY, ND.													
(Check only	(Check only 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner ee stated.													
A A	A													
296. SIGNATIFIE AND TITLE OF CENTIFIE	29c. LICENSE NUMBER O. C. M. E.							29d. DATE SIGNED (Month, Day, Year) ▶OCT. 14, 1995						
	D. C. FI. E. POCI. 14, 1993									1990				
AMON	01	111 H		Str	eet,	Ва	ltim	ore,	Mar	yla	nd 2	1201		
" OCT 1 6 1995	A CONTROL OF	PS VALEY.												

BALTIMORE, MARYLAND 21215-0020	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhis A hours after death, Page 6 may be retained by the hospital or attending physici
	hours after de
	2
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.4 ho
RECC	requires 1
- VITAL	ICIAN: The lav
DIVISION OF	DR ATTENDING PHYSI
-	-4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an analysis of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

	FOR STATE REGISTRAR	STATE OF MARYLANE	D / DEPARTME				HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)			*		2. DATE OF	DEATH		3. TIME OF DEATH
	WILLIAM BR	· MWV.				O C	10) 12/	95	11.10 B #
	4. SOCIAL SECURITY NUMBER		i. lest birthday) IF UN YRS. MONTI	IDER 1 YEAR HS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	BIRTH Say, Year) 916	8. BIRT	HPLACE (State or Foreign
œ	98. FACILITY NAME (If not institution, give stre	21	9b. C	ETY, TOWN O	R LOCATION OF DE			COUNTY OF	
СТО	RESIDENCE OF DECEDENT	Hospital		10				Bal	10
DIRECTOR	10e. STATE 10b. COUNTY	alto	10c. CITY, TOW	N OF LOCATI	ON				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	2603 LIGH	nt foot D	r.	101.	2120	9	10g.	CITIZEN OF	WHAT COUNTRY?
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ZNO .	If yes, spe	ENDENT OF HISPAN city Cuben, Mexica	IIC ORIGIN? (Specify Yes or No an, atc.)	Ble	CE — American Indian, ck, White, etc.
) BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	`	1 YES	2 NO Specify	<i>y</i> :		Spe	and lack
ETE	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	TION 16a. College (1-4 os 5+)	Give kind of work do	ne during mos	N I of working		ND OF BUSINESS		0 , 10
COMPLETED	124	NIA	Postm						es Post office
BE CO	17. FATHER'S NAME (First, Middle, Last)	ivoun			16. MOTHER'S NA		dle Maiden Surnar		
TO B	190, INFORMANT'S NAME (Typo/PA)	ne	196. MAILING ADDR	ESS (Street or	nd Number or Rural F	Poute Number,			21209
	20a/METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove	at from State 20b. PLA	CE AND DATE OF DISI	()		PATE 10/17/45			
	4 Donation 5 Other (Specify)							urel, i	nd
	Music	B. De	tt		h f. H				
	23. PART Enter the diseases, or complete fallure. Lie	mplications that coused the at only one cause on each	death. Do not en					y arreat,	Approximata
	IMMEDIATE CAUSE (Final disease or condition								Interval Between Onest and Death
	resulting in death)	HEPATIC DUE TO (OR AS A COM	ENCEP	MALC	PATH.	1			8 DAYS
NO	Sequentially list conditions, b.	HEPATO CON AS A CON	ELWU		CARCII				3 WEEKS
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		MEPATI	TIS	0	THE	ECTION	٧,	
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON							
	DART II Other Justilla and a set iii								
ICAL	PART II. Other significent conditions	contributing to death but no	ot resulting in the	Underlying	ceuse given in		PERFORMED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						_ '	YES 2 DEN	9	OF DEATH? 1 YES 2 NO
Z.	DID TOBACCO USE CONTRI				UNCERTAIN	1 🗆			
		HOSPITAL:	LACE OF DEATH (Che						
14S	1 YES 2 NO 1	Inpatient 2 ER/Outpatient 26e. DATE OF INJURY		Nursing Home	5 Residence				
ВУ Р	1°S Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	28c. INJU WOR		286. DEŞCRI	IBE HOW INJURY	OCCURED	
	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY — At building, etc. (Specify)	t home, farm, street, f	lectory, office		26f. LOCATIO City or To	ON (Street and Nur lown, State)	mber or Rurel	Route Number,
COMPLETED		AN: To the best of my knowledge							
00		On the beals of examination and	or investigation, in m	y opinion, de	ath occured at the	time, data and	d place, and due	to the cause(a) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	0.11.			29c. LICENSE NUM		29d.		D (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	ITEM 27) /France Orient		D410	10		out	121, 95
	JOGINDER P MEH	TA NORTHW	EST HUS	PITAL	CENTER	BA	VDALLS	TOWN	MD 71133.
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	E / *						10.77

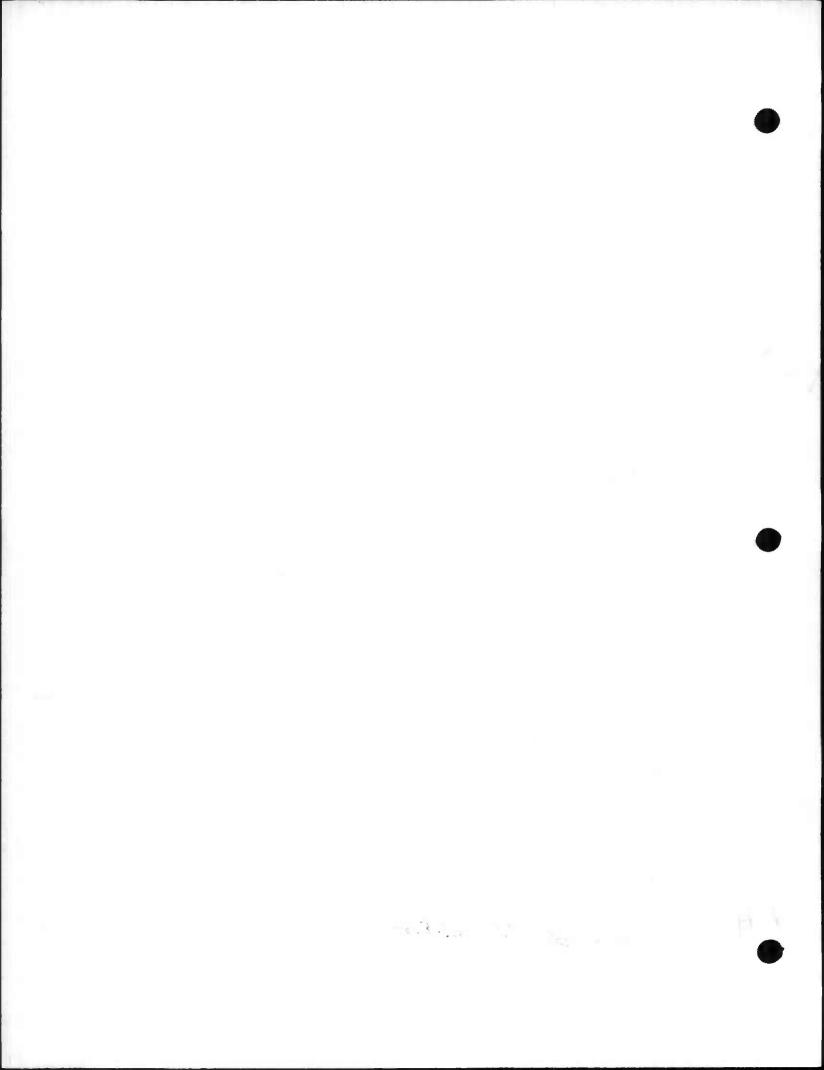
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEF	PARTMENT IFICATE	OF H	EALTH AND		HYGIENE REG. NO.		
		1. OECEDENT'S NAME (First, Middle Last)	iuman					2. DATE OF		443	3. TIME OF DEATH 8:30 A M
should	0	4. SOCIAL SECURITY NUMBER 215 22 7609 9e. FACILITY NAME (If not institution, give s	5. SEX 6. AGE (in yrs. lest birthday) 1 M 2 F 68 1 YRS. 6. AGE (in yrs. lest birthday) 1 F UNDER 1 YEAR 1 F UNDER 24 HRS. 7. DATE Of MONTHS 1 DAYS 1 HOURE 1 MIN. 1 NOV-1							8. BIRTH Count Ma	HPLACE (State or Foreign my) Lryland
.3	стоя	Liberty Medical Co	12-130-14		9b. CITY,		altimore		9c. C0	N/	
ii. Pages 1.	DIRE	100. STATE 10b. COUNT Maryland	imore			10d. INSIDE CITY LIMITS? 1X YES 2 NO					
n. ansit permit.	IERAL	100. STREET AND NUMBER 3707 Gwynn Oak A	ve.			10f	21207				WHAT COUNTRY? States
5-0020 nding physician. Is the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 1 YES IF YES, GIVE WAR OR DA	2 NO	H H	yes, spe	ENDENT OF HISPAN acify Cuben, Mexica 2 NO Specify	n, Puerto Rice		14. RACI Blac Spec	E — American Indian, k, While, atc. #y: Black
2121 lal or afte for use a	COMPLETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDER (Give kind life. Do NO	IT'S USUAL OCH of work done do T use retired.)	CUPATIO	ON st of working	16b. Kil	Const.		
YLA by the be det	ш	17. FATHER'S NAME (First, Middle, Last) (Unknown)		Bowman			,	ME (First, Midd	lle, Maiden Surneme		OII
MA retain 5 sho	TO B	190. INFORMANT'S NAME (Type/Print) Glord McGuire		19b. MAJI	ING ADDRESS		nd Number or Rural I	Poute Number,	City or Town, State, .	Zip Code)	07
e 6 m rector.		20a. METHOD OF DISPOSITION 1	com State com	atary, crematory	unt Cr	ema	tory 10	0ATE /12/95	20c. LOCATION -		
SALII r death. P le funeral al. examin		21. SIGNATURE OF PUNIERAL SERVICE LIC	Muraun_		CA	FA :	o aboress of fa Stephen Green Pa	D. Loh	rmann P	.A.	re,MD 21286
within 24 hours pletely filled in t cremation, or rei rent, the medi		23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition reaulting in daeth)	complications that caused Liet only one cause on ea a	vatra	o not enter t	he mo	de of dying, auci	h aa cardiec	or reapiratory a	errest,	Approximate interval Between Onset and Death
T.O. BOX 08 ath certificate be executeding physician and all Hygiene prior to burn. or other traumative.	ERTIFICATION	Sequantially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OUE TO (OR AS A OUE TO (OR AS A OUE TO (OR AS A	nio	E OF):	-a	ilure				
at the by the A inje	EDICAL C	PART ii. Other significent condition	ns contributing to death be	ut not resulti	ng in the und	erlying	j cause given in		PERFORMED? YES 2 10	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL KE te law request has been Dept. of	IAN: M	DID TOBACCO USE CONT			YES N		UNCERTAIN	V/			1 YES 2 NO
CERTIFICATE The State The State	PHYSICI	EXAMINER? 1 1 YES 2 NO 27. MANNER OF CEATH	HOSPIPAL: Inpetient 2 ER/Output 28s. DATE OF INJURY	ntlent 3 🗆 DO	OTHER:		5 🗆 Residence			COLIDEO	
After this death with	ΒY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJURY		INJURY M	1 🗌 Y	RK? ES 2 NO		BE HOW INJURY O		
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide S Could not be distarmined	building, etc. (Speci	ily)				City or To	ON (Street and Numb own, State)		Route Number,
4 4 2 E	COMPLET	(Check only	CIAN: To the best of my knowle R: On the bests of examination								and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIES	d. ohan	f mo			29c. LICENSE NUM	103	29d. D/	STE SIGNED	25 10 th 1995
+1		30. NAME AND ADDRESS OF PERSON WH TOSANCE L. 31. DATE FILED (Month Day Mar)	O COMPLETED CAUSE OF OEA	0	Type, Printy	be	to Mec	hel	Certan	Ba	bleme, no

TEGNICE L.

31. DATE FILED (MONIN, Day, Yarr)

OCT 1 6 1895



		1 - FOR STATE REGISTRAR	STATE OF MARYLA		IT OF HEALTH AND	MENTAL HYG		
		1. DECEDENT'S NAME (First, Middle, Last)	BUC			2. DATE OF DEAT MONTH OCT- /	DAY	YEAR 3. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 217-07-4381	5. SEX 6. AGE (II	82 YRS. MONTHS	ER 1 YEAR IF UNDER 24 HRS. BAYS HOURS MIN.	7. DATE OF BIRTI	H ar)	BIRTHPLACE (State or Foreign Country) M.D.
2, 3 should	OR	90. FACILITY NAME (II not institution, give s. CHURCH HOME	treet and number)	- /	BALTO, C	DEATH	9c. COUNT	Y OF DEATH
Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	N/A	10c. CITY, TOWN	OR LOCATION TIMORE	CIT		10d. INSIDE CITY LIMITS?
sit permit.	AL	100. STREET AND NUMBER 215 S, HiG	N ST		10f. ZIP CODE	CHY	10g. CITIZE	L∰TES 2 □ NO EN OF WHAT COUNTRY? USA
5-0020 nding physician. Is the burial-transit	Y FUNER	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 000	t WAS DECENDENT OF HISPA It yes, specify Cuban, Maxie 1 YES 2 NO Spec	ANIC ORIGIN? (Specifican, Puerto Rican, etc	y Yes or No— 1.	4. RACE — American Indian, Black, White, etc.
215-0 attending use as the	TED BY	3 Widowed 4 Divorced 15. DECEOENT'S EDUC (Specify only highest grade	CATION Completed)	16a. DECEDENT'S USUAL	-1		F BUSINESS/INDU	WHITE
D 21 spital or ed for	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	PRISON (Se	curi7	ý
YLA by the be det	BE CO	17. FATHER'S NAME (First, Middle, Last)	Bucci		IR MOTHER'S N	IAME (First, Middle, Mi	iden Sumame)	
be retain ge 5 sho e notifi	10	190. INFORMANT'S NAME (TIBO/Print) THERESA	Leone	196. MAILING ADDRE	SS (Street and Number or Rura West F	I FLD A		100 Z/222M
HORE e 6 may rector, pa		20e. NETHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rame 4 Donation 5 Other (Specify)	oval from State come	PLACE AND DATE OF DISPO		18/16 20	BRITO.	y or Town, Stata
death. funer		21. BIGMATURE OF FUNERAL SERVICE LIC	ENSEE	eV J	NAME AND ADDRESS OF F	CE4-SC	WS FU	Neval Home
hours after of in by the or removal.			omplications that caused List only one cause on ea	the death. Do not ente	r the mode of dying, su	ch aa cardlec or r	espiratory arres	t, Approximata Interval Between
d within 24 ompletely fille cremation, event, the		IMMEDIATE CAUSE (Final disease or condition resulting in death)	CONGE OUE TO (OR AS A	STIVE H	EART B	ALLUR	E	MonTHs
execute and control to buria	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):				
ortificate be piece prior prio	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			-	
the death ce y the attending Mental Hy		PART II. Other significent conditions	contributing to death by	t not requiling in the		- D		
	MEDICAL	DIABRE	TES M	ECCITU.	J Course given in	PEI	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
AL KECO ne law requires has been signs Dept. of Healt n 23 shows		DID TOBACCO USE CONTR				IN 🗆		1 🗌 YES 2 🚾 NO
SICIAN: The certificate h the State (YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 1 Inpatient 2 ER/Outpa	6. PLACE OF DEATH (Check thent 3 DOA 4 No.		8 Other (Specify)		
PHY His this C	ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c, INJURY AT WORK? 1 YES 2 NO	26d. DESCRIBE H	OW INJURY OCCU	RED
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED I	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY - building, etc. (Specif	— At home, farm, street, fa	ctory, office	26t. LOCATION (St City or Town, S	reet and Number or State)	Rural Route Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours	COMPLE		CIAN: To the best of my knowle					
王 王 是 万	BE C	296. SIGNATURE AND TITLE OF CERTIFIER			200 LICENSE NIL	IMBED	I and payer	HOUSE AL
P P 2 2	5	30. NAME AND ADDRESS OF PERSON WILL A . P . A Z .	COMPLETED CAUSE OF OEA	TH (ITEM 27) (Type, Print)	4 Has 21	TAI B	410	J. 13, 1995 up 21231
		31. DATE FILED (Month, Day, Year) OCT 1 6 1995	32. REGISTRAR'S SIGNA		-01 (10 2/26)	1 - 17/	1-1-1	173

3. TIME OF DEATH

12:290

10d. INSIDE CITY

14. RACE - American Indian, Black, White, etc.

white

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

10

Interval Between

Onset and Death

1 YES 2 NO

8. BIRTHPLACE (State or Foreign

CT

N7A

USA

Specify:

REG. NO.

2. DATE OF DEATH

2. DATE OF MONTH

FOR STATE REGISTRAR

MICHAEL

4. SOCIAL SECURITY NUMBER

1. DECEOENT'S NAME (First, Middle, Leat)

SEAN

5 SEX

BOX 68769
P.O.1
CORDS,
L REC
F VITA
ON OF
DIVISIO

7. DATE OF BIRTH (Month, Day, Year) 217-92-8741 1 3cM 2 - F 30 June 23,1965 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Mercy Hospital, Stella Maris Hospice DIRECTOR Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION Md Baltimore Catonsville permit. 10e. STREET AND NUMBER FUNERAL 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2029 Old Frederick Road funeral director, page 5 should be detached for use as the burial-transit 21228 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specity Yee or No-1 X Never Merried 2 Merried If yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 TES 2 NO Specify: В 3 Widowed 4 Divorced ETED. 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Fisherman Commercial 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) Robert Coppola Ħ BE Susanne Baier notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2029 Old Frederick Road Balto, Md. 21228 Susanne Magrogan hours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION
1 Burlet 2X Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 4 Donation 6 Other (Specify) 10/1 Beltsville. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home delah (4000 11 736 Edmondson Avenue, Balto. been signed by the attending physician and completely filled in by the nt. of Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, ahock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final the disease or condition resulting in death) AIDS event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disease Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 50 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the MEDICAL 24s. WAS AN AUTOPSY PERFORMED? requires that shows any 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: has b. Dept. ME 83 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL r this certificate ha item EXAMINER? HOSPITAL: 1 TYES 2 NO DR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) HOSPICE 27. MANNER OF DEATH 28e. OATE OF INJURY 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY Investigation After 3 Sulcide 26e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, Stelle) 6 Could not be determined 69 COMPLETED DIRECTOR: / 28 4 🗌 Homicide 29e, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. FUNERAL (HOSPITAL = 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) M. Hemman 040480 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5-810 BELAK 20 J. FERMANDO FERRO, MD BATTO 21206 31. OATE FILEO (Month, Day, Year)
OCT 1 6 1995 32. REGISTRAR'S SIGNATURE

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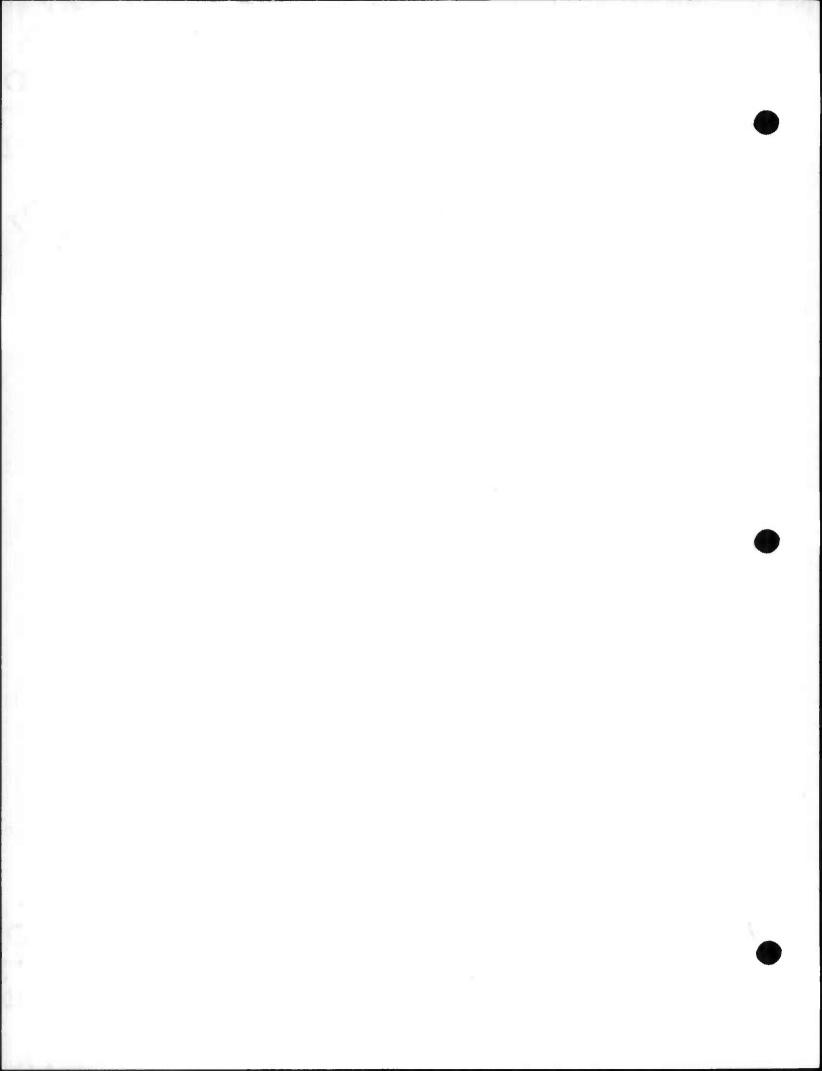
8. AGE (In yrs. lest birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Last)	MAS CALLANAN				2. DATE OF DEATH DAY OCTOBER 1	2,1995 YEAR	3. TIME OF DEATH 5:30 P. M			
	4. SOCIAL SECURITY NUMBER 215 30 8056	5. SEX 8. AGE (II	* **	FUNDER 1 YEAR ONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 07 19 34	8. BIRT	HPLACE (State or Foreign			
¥	9a. FACILITY NAME (If not institution, give s 3308 Foster Ave	(If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
ECIOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	v		10d, INSIDE CITY							
2	Md.	N/A		1 YES 2 NO							
FUNERAL	3308 Foster Ave	nue			10g, CITIZEN OF WHAT CO						
ž e	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)									
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT use i	k done during mo etired.)	st of working	U.S. (iness/industry Governme	nt			
COMP	12 17. FATHER'S NAME (First, Middle, Lest)	Callanan Cu	Section	superv.	18. MOTHER'S NA	ME (First, Middle, Maiden : erine A. Mu					
BE	Michael Joseph 19a. INFORMANT'S NAME (Type/Print)	Callanan Sr.	T son MAN BIG AS	DOBECC (Comme)		Route Number, City or Town					
2	Margaretta King	Callanan				timore, Md.	21224				
	20a. METHOD OF DISPOSITION 1 X Burlat 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from State cem	PLACE AND DATE OF etery, crematory or othe CCCO Hear	r place)		DATE 20c. LOC	Dundal				
	21. SIGNATURE OF FUNERAL SERVICE LI		~	Charle	es S. Ze.	iler & Son na St. Balt					
		List only one cause on e	ch line.	entar the mo	de of dying, auc	h as cerdisc or reepi	ratory arreat,	Approximeta Interval Between Onset and Death			
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. acul	CONSEQUENCE DE	rest	tial 4	fort	-	(Org			
N	Sequentially list conditions,			rec	Cali	eresule	· d'se	tel			
HTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	c	CONSEQUENCE OF):								
W I	that initiated eventa reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
AL C	PART II. Other aignificent condition	na contributing to deeth b	ut not resulting in	the underlyin	g ceuse given in	Part i. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
MEDIC	thenee.	Lilson	-	/		1 YES 2	Ling	OF DEATH?			
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O		NO [UNCERTAI	N 🗆					
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 W NO	HOSPITAL:		OTHER:							
PHYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. IN.	URY AT ORK?	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED				
BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, atr		YES 2 NO	28f. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,			
ETED	4 Homicide determined										
COMPLE	(Check only	SICIAN: To the best of my know ER: On the basis of exemination						r(a) and manner as stated.			
BEC	29b. SIGNATURE AND TITLE OF CERTIFIE	ER COLUMN	?>		29c. LICENSE NU	MBER 300	29d. DATE SION	ED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F		700	1 CTTOR	(27)	BACT.			
	31. DATE FILED (MORT. FOOTE)	31 REGISTRARIS GN	•			14/014	81:	1005135			
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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and an accompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be find within 25 hours after death with the Case Date of Managin Linguistics of Mana

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

		TIEGIOTTIAN.					IN I III	CALE	Ur	DEAL	П		REG. NO.			
	MONTH DAY OCT 13 1995										3. TIME OF DEATH					
		4. SOCIAL SECURITY NUMBER 219-18-8327		5. SEX 1 X M 2 □ F	8. AGE (In)	yrs. last		IF UNDER	YEAR	IF UNDER	24 HRS. MIN.	7. DATE OF JULY	BIRTH my Year) n	006	e. BIRTH	PLACE (State or Foreign
			-		09		YRS.						31 1			and the second
	r I	98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 523 S. Washington Street Baltimore City Baltimore City														
	EC CH	RESIDENCE OF DECED	ENT													.c ozcy
	DINE		Balt	timore Ci	ty			alti		Cit	у					10d. INSIDE CITY LIMITS? 1 X YES 2 NG
- ;	Z I	10e. STREET AND NUMBER							101	ZIP CODE				10g. CITI	ZEN OF W	HAT COUNTRY?
	PUNERAL	523 S. Washi	ngto	n Street						212	31			US	SA	
	פו דט	t1. MARITAL STATUS 1 Never Married 2 Marri 3 Widowed 4 Divorced	ed	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES :	2 NO	NED O	, M	yes, sp	ENDENT OF	, Mexicar	IC ORIGIN? (5 n, Puerto Rica	ipecify Yes in, etc.)	or No-	t4. RACE Black Speci Whii	— American Indian, , White, stc.
1	3	15. DECEDEN	T'S EDU	CATION		Sa. DEC	EDENT'S	USUAL OC	CUPATIO	N		16b, KI	ND OF BUS	INESS/IND		.ce
		(Specify only high Elementary/Secondary (0-12)	est grade	College (1-4 or 5 +)	life. I	e kind of w Do NOT us	rork done di e retired.)	uring mo	it of working	7					
. 3	[]	4th				Pai	nter					S	elf-	emplo	yed	
at once.	COMPLE	17. FATHER'S NAME (First, Middle,		1 0								ME (First, Mide				
20		Henry Wilbur	_	ley Sr.				<u></u>				/iola				
pate	2	Georgia C. Cr		y		19b.	MAILING 23 S	. Wa	Shi	ng ton	St,	oute Number, Balt	imor	e, MD	2123	1
must b		20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spec		oval Irom State	20b. PL cemete	ACE AN	Lawr	r bisposi her place) L Cem	rion (Na ete:	ne of	(oate Oct17		cation — c timor		wn, Stafe
examiner must		Dean P Cha	rite	M								al Ho		more	MD	21221
medical	٦	23. PART I. Enter the diseas	es, or c	omplications that	caused th	ne dee	th. Do n									Approximate
vent, the		immediate Cause (Final disease or condition resulting in death)	fallure.	a. DUE TO	OR AS A CO	onsEqu						CV				interval Batween Onset and Death
or other traumatic		Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):														
-		PART il. Other eignificant co	ndition	a contributing to	death but	not re	aulting is	n the unc	erivino	ceuse di	ven in f	Part i. 24	. WAS AN	ALITOPSY	24h	WERE AUTOPSY FINDINGS
ws any Injury,													PERFOR	MED?	4	AVAILABLE PRIOR TO COMPLETION OF CAUSE
W F												_ '	_ 129 2	L)AV		OF DEATH? 1 YES 2 NO
		DID TOBACCO USE O	ONTE	RIBUTE TO CAL	USE OF I	DEAT	H YE	S N	0 🗆	UNCE	RTAIN				100	
item 23		25. WAS CASE REFERRED TO MED EXAMINER?	HCAL		26.	PLACE	OF DEAT	H (Check or								
or it		t TYES 2 NO		HOSPITAL:	ER/Outpatie	ent 3 [DOA	OTHER: 4 Nursi		5 D R60	idence (6 Other (S)	pecify)			
marked, or item 23 s	- 8	27. MANNER OF DEATH 1 Actural 5 Pending Investi	ng Igation	28a. DATE OF (Month, Da			28b. TIME INJU		86c. INJU WOI 1 Y		NO	28d. OEŞCRI	BE HOW IN	JURY OCC	URED	
28 is		3 Suicide 8 Could 4 Homicide determ		28e. PLACE Of building, o	INJURY — . etc. (Specify)	At hom	e, ferm, s	reet, facto	y, office			281. LOCATIO	N (Street e: wn, State)	nd Number	or Rural A	oute Number,
ANT: If Item				CIAN: To the best of a												and menner as stated.
IMPORTANT:		29b. SIGNATURE AND TITLE OF C	5	-3,						29c. LICEN	SE NUM	BER 20	>	29d. DATE	SIGNED	Month, Day, Year)
		30. NAME AND ADDRESS OF PERSON S. S. D. A. V. 31. DATE FILED (Month, Dily, Year) OCT 1 6 1995	F M	32. REGISTRAF	P'S SIGNATO	GF	27) (Type,	ele	46	A	10C)	Ra	Ct	Jack		2/222
		30. = 9 1000	Jak	- I would	A COLUMN TO	4										

ages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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COMPLETED

4 Homicide

8 Could not be

31025 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 9.15 A 50 4. SOCIAL SECURITY NUMBER 218-07-8/28 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 915 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH cott DIRECTOR oward RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 10a STATE 10b. COUNT mo oward CI 1 TYES 2 NO 21042 FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? eld Dr. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

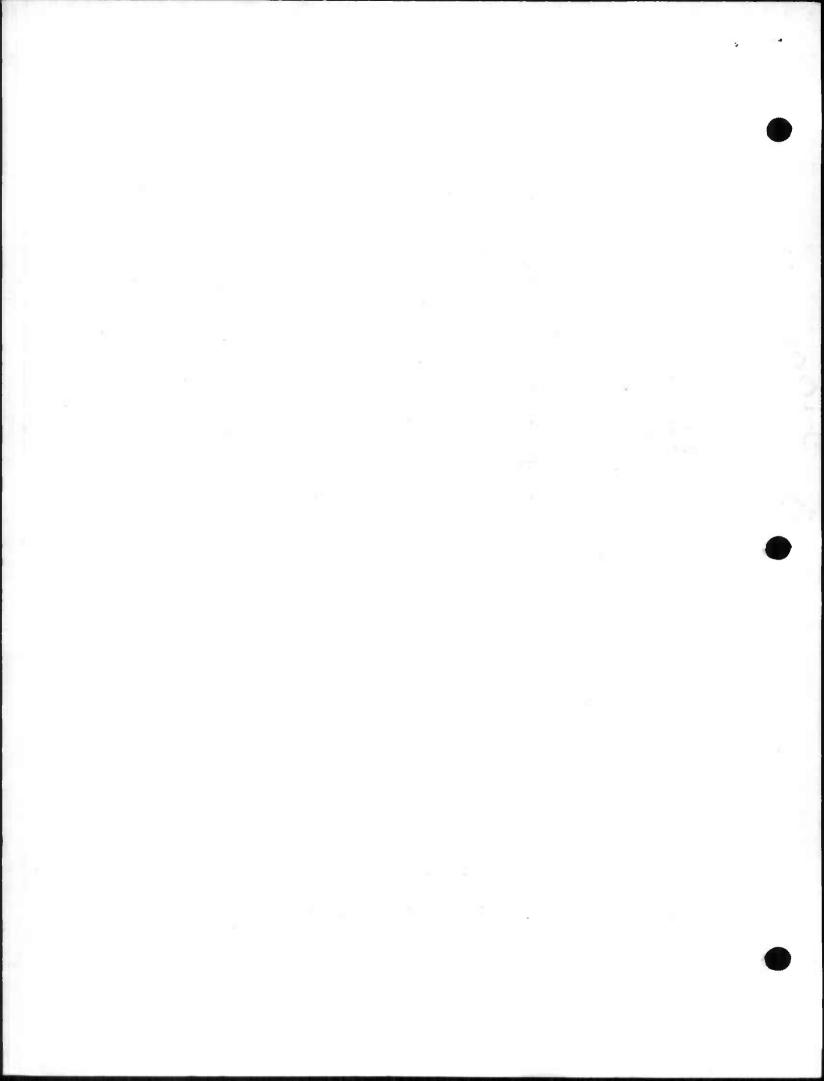
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 1 Never Married 2 Married Black BY 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Service Supervisor rosta 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname, homas Noah Coleman Sadie BE 19a, NFORMANT'S NAME (Type/Print) 2 Dr. ardle Oleman 3/04 iamfield Ellicottcity 21042 20e, METHOD OF DISPOSITION
1) Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of company, cre-hatery or other place) eme 20c LOCATION - City or Town State

Ellicott City, 10/17/45 Cemeter mol 21. SIGNATUREJOF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY F.H. Wes 300 23. PART I. Error the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart feilure. List only one ceuse on each line IMMEDIATE CAUSE (Finel Onset and Death metastalic prostate dieease or condition resulting in death) CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) thet initieted events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 💆 NO 🗌 UNCERTAIN 🗎 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) **EXAMINER?** 1 YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — building, etc. (Specify) 3 Suicide At home, farm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED/(Month, Day, Year) 013998 ED CAUSE OF DEATH (ITEM 27) (Type, Print) Stahl 4801 Darsey Hall 31. DATE FILED (Month, Day, War) 0CT 1, \$ 1995 3. REGISTRAR'S SIGN

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, end due to the cause(e) and π

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion.



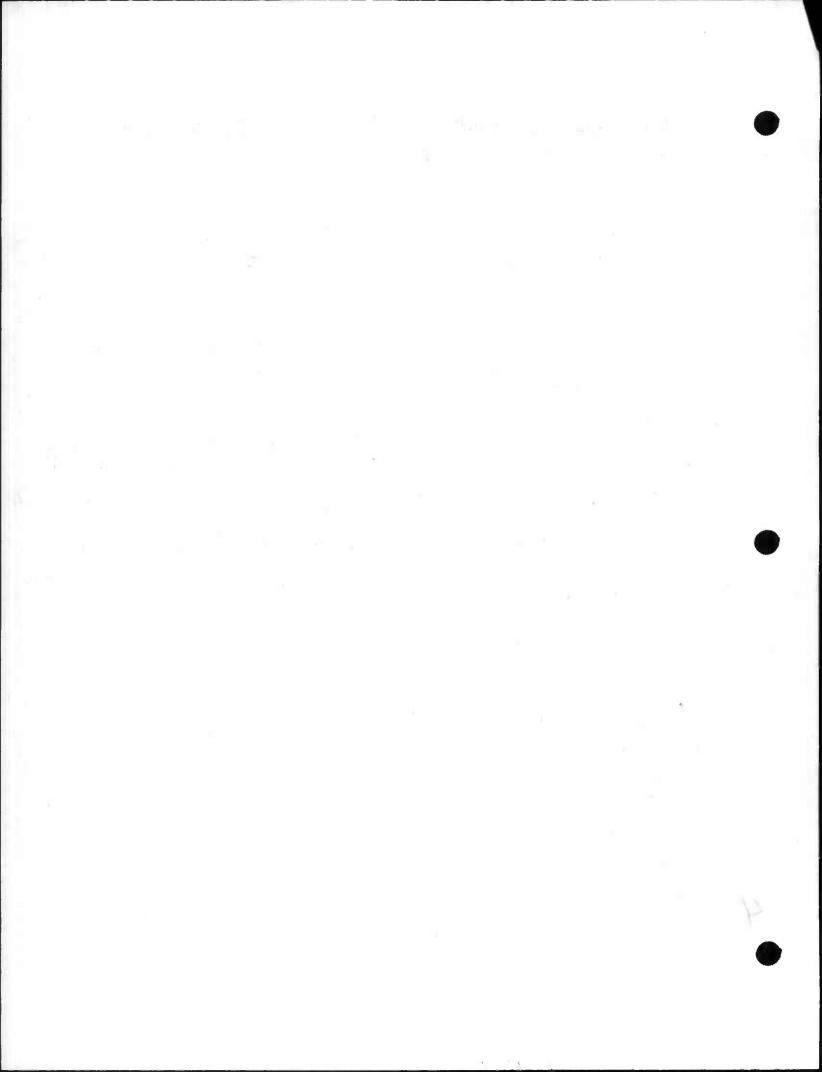
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

ATTENDING PHYSI
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	CENTIFIC	ALE OF DEALE	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Level) TYP N. F. Chambers		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)	UNDER 1 YEAR	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign.						
	213-10-3203 1 N 2 DF YRS.	NTHE DAYS HOURS MIN.	3-20-1918	Maryland						
œ	9a. FACILITY NAME (If not institution, give street and number)	CITY, TOWN OR LOCATION OF DE		TY OF DEATH						
DIRECTOR	RESIDENCE OF DECEDENT	valtim	ore 1	NA						
뿐	10a. STATE 10b. COUNTY 10c. CITY, T	OWN OR LOCATION	. ~	10d. INSIDE CITY LIMITS?						
	10e. STREET AND NUMBER	10f, ZIP CODE	10a, CITI	1 YES 2 □ NO ZEN OF WHAT COUNTRY?						
FUNERAL	4825 Wilern Ave	2121	5 1	1.S.A.						
F	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	If yes, specify Guban, Mexica		14. RACE — American Indian, Black, White, etc.						
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	1 TES 2 NO Specific	y:	Specify: Black						
		done during most of working	16b. KIND OF BUSINESS/IND	USTRY						
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) HOUSE		Hosp	MAL						
NO.	17. FATHER'S NAME (First, Middle, Lest)		ME (First, Middle, Meiden Surname)							
BE	Henry Jobes		inor ra	Herson						
2	190. INFORMANT'S NAME (Type/Print) Gwenddyn S: Fraling 4825	Wilem Ave.	Route Number, City or Town, State, Zip	1						
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF D	ISPOSITION (Name of	Datt more							
	4 Donation 5 Other (Specify)	100 cemeter								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	vancy in.	Wallace Fun.						
	23. PARTY Enter the diseases, or complications that caused the daeth. Do not	3405 W. F	ranklin St.	Battand 21229						
	immediate Cause (Final		1	Interval Batween Onset and Death						
	disease or condition	zuKem	10	1 Month						
	OUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate									
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
- 11	d									
EDICAL	PART II. Other algnificant conditions contributing to death but not reaulting in the undarlying cause given in Pert I. 24e. WAS AN AUTOPSY PREFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE									
			1 TYES 2 NO	OF DEATH?						
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)								
14S	1 YES 2 NO 11 Inpetient 2 ER/Outpetient 3 DOA 4	Nursing Home 5 - Residence								
	1 Netural 5 Pending (Month, Day, Year) INJURY	F 26c, INJURY AT WORK? M 1 YES 2 NO	26d. DESCRIBE HOW INJURY OCC	TURED						
ED BY	2 Accident Investigation 3 Suicide 6 Could not be building, stc. (Specify)		261. LOCATION (Street and Number of City or Found State)	or Rural Route Number,						
	4 Homicide detarmined City or Town, State)									
COMPLET	29a. CERTIFIER (Check only one) AMDICAL SYMMETER OF the best of my knowledge, dasth occurred at the control of the best of my knowledge, dasth occurred at the control of									
8	one) 2 MEDICAL EXAMINER: On the basis of axaminetion and/or investigation, in 29b. SIGNATURE AND TITLE OF CERTIFIER									
H	10 Herry IND	29c. LICENSE NUN	18ER 29d. DATE	SIGNED (Month, Day, Year)						
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print	11 - 10	24/14	(1199)						
	JESUS HEUSON 2401 West	- Belvedore	Ave. Baltin	nue MO2145						
	31. DATE SUED CHOME DE CHARTS SIGNATURE 32. DECISTRAR'S SIGNATURE 32. DECISTRAR'S SIGNATURE 32. DECISTRAR'S SIGNATURE									



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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	TEGISTIAN			_	ONIL	JI DEAII		ned. No.			
	To be if a County DAY YEAR - 44									3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	GE (In yrs. Insi	last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				TOTAL MARKET STATE OF THE STATE				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In 230-14-7096 1 □ M 2 □ x F 93				MONTHS DA	-	MIN.	(Month, Day, Year) Sept 18,	1902	Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TO	WN OR LOCATION				NTY OF DE	EATH
Œ	Bayview Medical Center				Balt	imore			1	N/A	
K	RESIDENCE OF DECEDENT					2111-07-0				N/A	
Ĭ,	10e. STATE 10b. COUNT	Υ		10c. CITY	, TOWN OR L	OCATION					tod. INSIDE CITY
DIRECTOR	Md Bal	C	atons						1 YES 2 NO		
A	100. STREET AND NUMBER					10f. ZIP CODE			10g. CIT	IZEN OF W	THAT COUNTRY?
FUNERAL	715 Maiden Choic	e Lane				21228				USA	
5	11. MARITAL STATUS	12. WAS DECEDENT EV						ORIGIN? (Specify Yes	or No-		- American Indian, White, etc.
	1 Never Married 2 Married	FORCES? 1 1		10		YES 2 X NO		Puarto Ricari, etc.)		Specif	
BY	3 ▼ Widowed 4 Divorced					46					white
6	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	SINESS/INC	DUSTRY	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	Do NOT us	rork done durin e retired.)	g most of working					
7	UNKNOWN	Conege (1-4 of 5 +)	F	Homem	aker			Own	1 Hon	16	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18 MOTHE	B.6 NVN4	(First, Middle, Maiden			
	John Pugh							hardson	unun indiffre)		
BE											
10	19a. INFORMANT'S NAME (Type/Print)							ite Number, City or Tow			
-	Elizabeth Chesno			21 Hi	11top	Place,	Balt	imore, Mo	1. 21	228	
	20a, METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ren	aller a terigina			F DISPOSITIO	N (Name of		DATE 20c. LO	CATION -	City or To	wn, State
	4 Donation 5 Other (Specify)	Novel from State	Fores	matory or of	mer plece) wn Cen	netery		10/17 Norf	1014	17.2	
	21. SIGNATURE OF FUNERAL SERVICE LI	ICENOSE				E AND ADDRESS	OF FACIL	ITY	VII.	711	
	D. D. J.	(dallo			Ste	rling A	shto	n Funeral	Hom	ie	
_	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between										
	IMMEDIATE CAUSE (Final									Onset and Death	
	disease or condition resulting in daeth) Nentricular fachy Cardia DUE TO (OR AS A CONSEQUENCE OF):									lweek	
	DUE TO (OR AS A CONSEQUENCE OF):										
-	, F / 1										
CERTIFICATION	Sequentially list conditions,										
AT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Please or India)									Duear	
F	CAUSE (Disease or injury that initiated events	1.19		^							
E	resulting in death) LAST	- 40 L	7510	a bini	d	infect	an		ZDINEAN		
圆		d	10	1 0/0/							
	PART II. Other algnificent condition	na contributing to dea	th but not i	reaulting	in tha under	rlying cause giv	ven in Pa	ort I. 24s. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	Ala omi	na Dai	10					PERFOR	1		AMILABLE PRIOR TO COMPLETION OF CAUSE
G								- I T TES 2	Tomo		OF DEATH?
≥								_			1 - YES 2 00
Z	DID TOBACCO USE CONT	KIBUTE TO CAUS					RTAIN				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEAT	H (Check only	one)					
S	1 TES 2 NO	1 patient 2 ER	/Outpatient 3	□ DOA	OTHER:	Home 5 🗆 Resi	Idence 6	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28b. TIM		c. INJURY AT	2	ed. DESCRIBE HOW	NJURY OC	CURED			
	(Month, Day, Year)				W 1	WORK?	NO				
BY	2 Accident Investigation	ome farm			_	PRE LOCATION (Street	and Numbe	w or Rural F	Soute Mumber		
B	4 Humicide determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or fown, State)									
E											
చ	Check only	SICIAN: To the best of my	knowledge, de	esth occum	ed at the time	data and place, a	end due to	the cause(a) and ma	nner as str	eted.	
COMPLETED	one) 2 MEDICAL EXAMIN	IER: On the beals of axemi	nation and/or	Investigation	n, in my opin	ion, death occured	d at the tir	me, data and place, ar	nd due to t	he cause(s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CENTIFIC	en -				29c, LICEN	CE MINIO	E0	204 DA	TE SIGNED	(Month, Day, Year)
BE	CX.	Privar				Di I	C CO		D /	mat .	lot as III was
2		IWIU				0	001	0	1	NO	14,199
FT :	30. NAME AND ADDRESS OF PERSON W	_	F DEATH (ITE	M 27) (Type	Print)				11	.045	
	JENNY LUN	-	777	UZ	HST	CHN	11	ve., Br	1140	m	A2212 C
	31. DATE FILED (Mary Day, Mar)	32. HEIGHT BARY	SIGNATURE.	Rocks !	2						
			The second second second		₹						



	1	157-12-0637 1XM2 DF 8	YRS
pluods		Se. FACILITY NAME (If not institution, give street and number)	
2,3	DIRECTOR		1201
es 1,		RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	10c. 0
å.	H H	Md Howard	
n nemit		10e. STREET AND NUMBER	
-0020 ing physician. the bunial-transit permit. Pages	FUNERAL	3515 N. Chatham Road	
20 ysiciau nial-tra	J.	11. MARITAL STATUS 12. WAS DECEOENT EYER II 1 Never Married 2 Married FORCES? 1 \(\) YES	N U.S. ARMED
de ph	BY	3 Wildowed A Discovered IF YES, GIVE WAR OR D	ATES
BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the hospital or attending physician the funeral director, page 5 should be detached for use as the bunial-trainer. must be notified at nace.		15. OECEDENT'S EDUCATION	16a. DECEDENT
212	E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind a life. Do NOT
AND 21215. The hospital or attend detached for use as	COMPLETE	12	C1
the hos detach	9	17. FATHER'S NAME (First, Middle, Last)	
RYL Md by	5	Bernard Dobbs	
MAR) retained to	2	19e. INFORMANT'S NAME (Type/Print)	19b. MAILI
A be page 5		Catherine Dobbs 200. METHOD OF DISPOSITION	3515
MORE age 6 may director, pa		1X Buriel 2 Cremetion 3 Removal from State	PLACE AND DAT
Page 6 Indicate must		21. SIGNATURE OF FUNERAL SERVICE DICENSEE	rrison
ALTIN death. Pag e funeral dir		My X Calida	6100
E _ 2 7		23. PART I. Enter the disesses, or complications that caused	Moor
To or		ahock, or heart fallure. List only one cause on e	ach line.
within 24 hor npletely filled cremation, or		IMMEDIATE CAUSE (Final disease or condition	TONG
ted within completely ial, cremati, if		resulting in death) a, DUE TO (OR AS A	CONSEQUENCE
687 precuted and con burial,		PERFO	RATE
OX 68 e be execut sician and c rior to buni traumatic)E	it any, leading to immediate	CONSEQUENCE
hcate be ophysician ne prior to	2	CAUSE (Disease or Injury	11/1/2
D.O. En certifical anding phy Hygiene per other	Ē	that initiated events DUE TO (OR AS A resulting in death) LAST	CONSEQUENCE
		d	
RDS, at the deat by the att and Menta	AL	PART II. Other aignificant conditions contributing to death b	ut not resultin
Signed by Health and	CIAN: MEDICAL		
RECO v requires the been signed to of Health shows are	×		
e law has be Dept.	A	DID TOBACCO USE CONTRIBUTE TO CAUSE O	
VITAL AN: The law tificate has b e State Dept r Item 23	SICI	EXAMINER? HOSPITAL:	26. PLACE OF DE
	>	1 ☐ Inpatient 2 ☐ R/Outp 27. MANNER OF DEATH 28e. DATE OF INJURY	atlent 3 U DOA
NG PHYSI fer this cleath with marked.	₽	Month, Day, Year)	
NOING NOING L: Afte r: deat		Accident Investigation 3 Suicide 8 Could not be	— At home, farm
DIVISION OF OR ATTENDING PHYSIC OIRECTOR: After this ce hours after death with ti llem 28 is marked,		4 Homicide determined building, etc. (Spec	ну)
DIV L DR / DIREI hours	2	29e. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of my knowl	edge, death occu
DIVISION OF 17 THE HOSPITAL OR ATTENDING PHYSICI. THE FUNERAL DIRECTOR: After this car fised within 72 hours after cleath with the PORTANT: If item 28 is marked, o		one) 2 MEOICAL EXAMINER: On the beels of exemination	and/or investiga
TO THE HOSPI TO THE FUNER DE RIED WITHIN	BE C	296. SIGNATURE AND TITLE OF CENTIFIER	
5 5 8 W	10 B	111070111111	m
~	=	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	
0		RINDER 22 S. GRE	5021N B

	1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM	MENT OF HEAL	TH AND ME	NTAL HYGIEN	E			
	1. OECEDENT'S NAME (First, Middle, Last)				2.	DATE OF OEATH		3. TIME OF DEATN		
	Victor	Dobbs				OCTO BEA		95 3:28 AH		
	4. SOCIAL SECURITY NUMBER 157-12-0637	1.1		UNDER 1 YEAR IF UN	NDER 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
	90. FACILITY NAME (If not institution, give	1 - 8	YRS.	b. CITY, TOWN OR LOC		uly 10,		New York		
8		none Md 2		Balt			9c. COUNTY	Y OF DEATH		
וַבָּן	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT		40- 0074 7	OWN OR LOCATION						
DIRECTOR		ward		licott Ci	tv			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	10e. STREET AND NUMBER			101. ZIP C	-		10g. CITIZEI	N OF WHAT COUNTRY?		
FUNERAL	3515 N. Chatham	11.		210	42			USA		
J.	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEOENT EVER IN FORCES? 1 1 YES		13. WAS DECENDEN	NT OF HISPANIC C	ORIGIN? (Specify Yes	or No- 14	. RACE — American Indian, Black, White, etc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES 2 X	NO Specify:			Specify: White		
COMPLETED	15. OECEDENT'S EDU (Specify only highest grad	JCATION completed)	16a. DECEDENT'S USI	UAL OCCUPATION done during most of we	notino	16b. KIND OF BUS	SINESS/INDUS			
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)	Uning					
S S	17. FATHER'S NAME (First, Middle, Last)		cter.		1071170101111111		rment			
	Bernard Dobbs			0.000		First, Middle, Meiden : ne Rutkas				
TO BE	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Nun				ode)		
	Catherine Dobbs		3515 N	. Chatham	Road,	Ellicott	City,	Md. 21042		
	20e, METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Ren	novel from State 20b.	PLACE AND DATE OF O	NSPOSITION (Name of place)				y or Town, State		
5	4 Donation 5 Other (Specify)		etary, grematory or other Prison For	rest Vet (0/16 Balt	timore	, Md.		
		0-1.4	ñ.	Sterling	Ashton	Funeral				
3	23. PART I. Enter the disesses, or	complications that caused	N CONT.	736 Edmo	ndson A	venue, Ba	alto,	Md. 21228		
	ahock, or heart failure. IMMEDIATE CAUSE (Final	List only one cause on ea	ch line.	amer the mous or	dying, such sa	cerdiac or reapi	ratory srres	Interval Between		
5	disease or condition resulting in death)	PERIT	rowit	is				Onset and Death		
	DUE TO (OR AS A CONSEQUENCE OF):									
NO N	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
SAT	If any, leading to immediate cause. Enter UNDERLYING	. UNDER	12/10//-	() (T.EN	R				
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	reaulting in death) LAST	d								
4	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS									
MEDIC						PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME								1 TES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				NCERTAIN []	1.0			
Sici	EXAMINER?	HOSPITAL:		THER:		30.70.00				
Ä	27. MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME OI			Other (Specify) I. DESCRIBE NOW IN	JURY OCCUR	ED		
ВУР	Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES						
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specifi	— At home, farm, stree	t, factory, office	281	LOCATION (Street as City or Town, State)	nd Number or i	Rural Route Number,		
E I										
COMPLETED	29e. CERTIFIER (Check only one)	ICIAN: To the best of my knowle	dge, death occurred at	t the time, date and pla	lace, and due to th	ne cause(s) and man	ner se stated.			
		ER: On the beele of exemination	and/or investigation, in	my opinion, death oc	ccured at the time.	, data and place, and	due to the c	nuse(s) and manner so stated.		
BE	296. SIGNATURE AND TITLE OF CENTIFIE	1//	in MA	29c. L	LICENSE NUMBER	505	29d. DATE SI	GNED (Monthy Day, Year)		
임	30. NAME AND ADDRESS OF PERSON WI	O COMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type, Prin	n)	175	0 >	10	112/73		
	RINDER 3			ST.						
	OCT 1 6 1995	32. REGISTRAR'S SIGNAT		<u> </u>	·					
1	001 T 0 1323	THE WILLIAM STATES	Talls							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

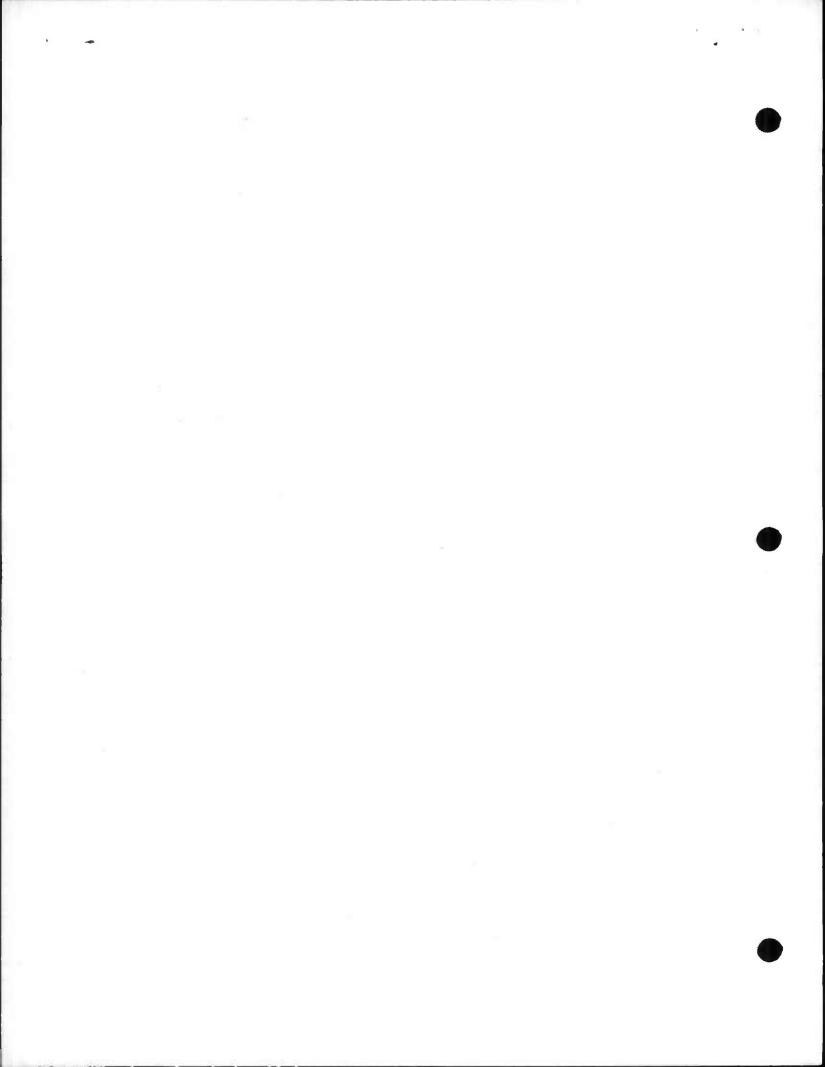
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MEN	TAL HYGIEN	E		
	1. OECEDENT'S NAME (First, Middle, Lest) A SOCIAL SECURITY NUMBER	CONRAD 5. SEX	B. AGE (In yrs. leat	26	PUI I	d		00	ATE OF OEATH DA	. /	995	3. TIME OF DEATH
	2/Z = 0) - ZZ-15 So. FACILITY NAME (If not institution, give str	# M 2 F	80	YRS.	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	No	vember 2		Country	Maryland
DIRECTOR	Mercy Medical Ce	nter					more , C			SC. COO.	N/A	AIR
REC	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCAT	ION					10d. INSIDE CITY
	Maryland 100. STREET AND NUMBER	N/A		Ba	altimo		City					LIMITS?
ERA	4800 Seton Drive					101	21215			10g. CITI		A A
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA WW]	YES 2 N	MED O	If 1	res, spi	ENDENT OF HISPA polity Cuben, Mexico 2 X NO Specific	an, Puer	GIN? (Specify Yes no Rican, atc.)	or No-	U.S 14. RACE Black, Specify	- American Indien, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12)	ATION completed) College (1-4 or 5 +)	(Gh	ve kind of v Do NOT us		ring mo	at of working		18b, KIND OF BUS			and the same of th
OMF	17. FATHER'S NAME (First, Middle, Lest)		Adm:	inis	trativ	ve	Divison		Veteran:		ninis	tration
ш	John Dippold								e Enge	,		
TO B	190. INFORMANT'S NAME (Type/Print)						nd Number or Rural	Route N	umber, City or Town	n, State, Zip		
	Miss Diane Dippol 200. METHOD OF DISPOSITION		20b. PLACEA				Street-	7		, Va.		
	1 X Burlel 2 Cremetion 3 Remo		Parkwo	notory or o	cemete	ery	1	0/1	7/95 Ba	altim	ore	, Maryland
	21. SIGNATURE OF FUNERAL SERVICE UC	she Sh.	/		22 NA L 6	on a	and J. R	UCK	Funeral	l Hom	e, I	nc.
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between										Approximate	
	The state of the s								Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
7	PERFORMEO? ANAL COM								WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Σ :	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	H (Check onl	y one)						
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)				DOA 4 Numing Home 5 Residence			6 Other (Specify) 28d. DE\$CRIBE HOW INJURY OCCURED				
	2 Accident investigation 3 Suicide 8 Could not be determined 4 Homicide determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number of Number								ute Number,			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI CHOCK ONLY 2 MEDICAL EXAMINER											and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	ON B	row	29c. LICENSE NUM						Month, Day, Year)		
- 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	27) (Туре,	Print)		200	0	10.		0	

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month Day, Year) 0CT 1 6 1995



FOR STATE REGISTRAR

CARMELO

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

1 -

YEAR

1995

3. TIME OF DEATN

8. BIRTNPLACE (State or Foreign

0225

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REG. NO

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2. DATE OF DEATN MONTH

7. DATE OF BIRTN

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DIVISION	Contraction of the contraction o
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IF UNDER 1 YEAR IF UNDER 24 HRS. 219-38-3657 HOURS 1 TyM 2 🗌 April 17 Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 11930 HARFORD ROAD GLENARM BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MD 1 TES 2 NO Baltimore Parkville/Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 16g, CITIZEN OF WHAT COUNTRY? burial-transit 3212 Sperl Court 21234 SA hours after death. Page 6 may be refained by the hospital or attending physician. led in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puarto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married Specify White 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced 60 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Barber-Proprietor Barber Shon once. 17. FATNER'S NAME (First Middle Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 76 Salvatore DiForte BE Grace Castagna notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JoAnne M. DiDorte 3212 Sperl Court Baltimore. Maryland 21234 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must Greenmount Crematory 10/17/95 Baltimore, Md 22. NAME AND ADDRESS OF FACILITY The Dippel Funeral Home Inc examiner 7110 Belair Road Balto. Md 21206 npletely filled in by the cremation, or removal. the medical 23. PARTU Enter the diseases, or conditions that squeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel Multiple disease or condition 24 Injuries resulting in desth) event, DUE TO (OR AS A CONSEQUENCE OF to burial, c other traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): ending physician a Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events attending resulting in death) LAST 10 the atten Mental h injury, PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL and PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATN? been signed b 1 YES 2 NO Shows YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: has be Dept. 34 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL DIRECTOR: After this certificate I hours after death with the State OTHER:
4 □ Nursing Home 5 □ Residence 8 NOther (Specify) AT SCENE HOSPITAL 1 X YES 2 NO | | Inpatient 2 | ER/Outpetlant 3 | DOA 10 280. DATE OF INJURY TOWN ARB. TIME OF INJURY 10 - 14-95 0104 27. MANNER OF DEATN 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, culysiva 1 Natural 5 Pending Investigation 0104 1 YES 2 W NO -auto fixed object BY 2 Accident 28e. PLACE OF INJURY — At home, larm, street, lectory, office building, stc. (Specify)

LOULE COMMON 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 50 6 Could not be COMPLETED 4 Nomicide 28 11930 Har Item 29a. CERTIFIER
(Check only one)

253 MEDICAL EXAMINED, On the best of my knowledge, desth occurred at the time, data and place, and due to the cause(e) and manner as stated. 8 TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examigration and/or investigation, in my opinion, dasth occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 6 O.C.M.E OCT. 14. 1995 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Buler 111 Penn Street, Baltimore, Maryland 21201 32 REGISTRAR'S GNATURE **DHMH-18 Rev 1/89**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DIFORTE

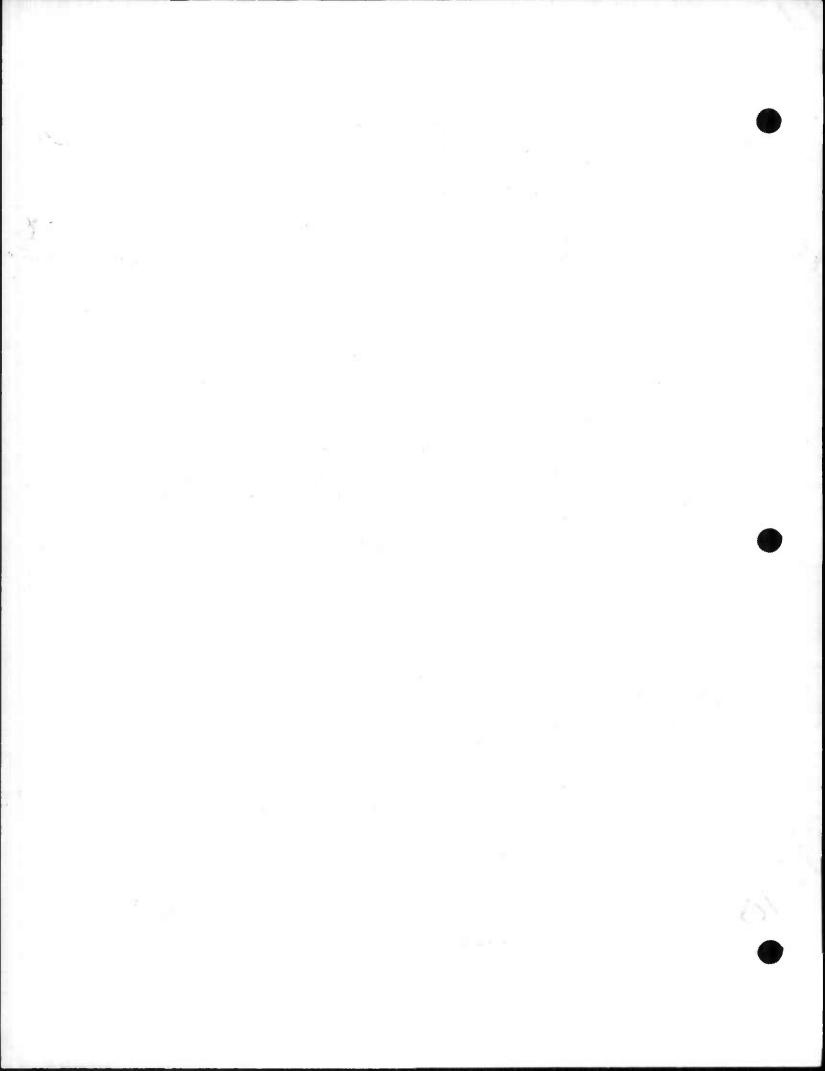
SALVATORE

6. AGE (In yrs. last birthday)

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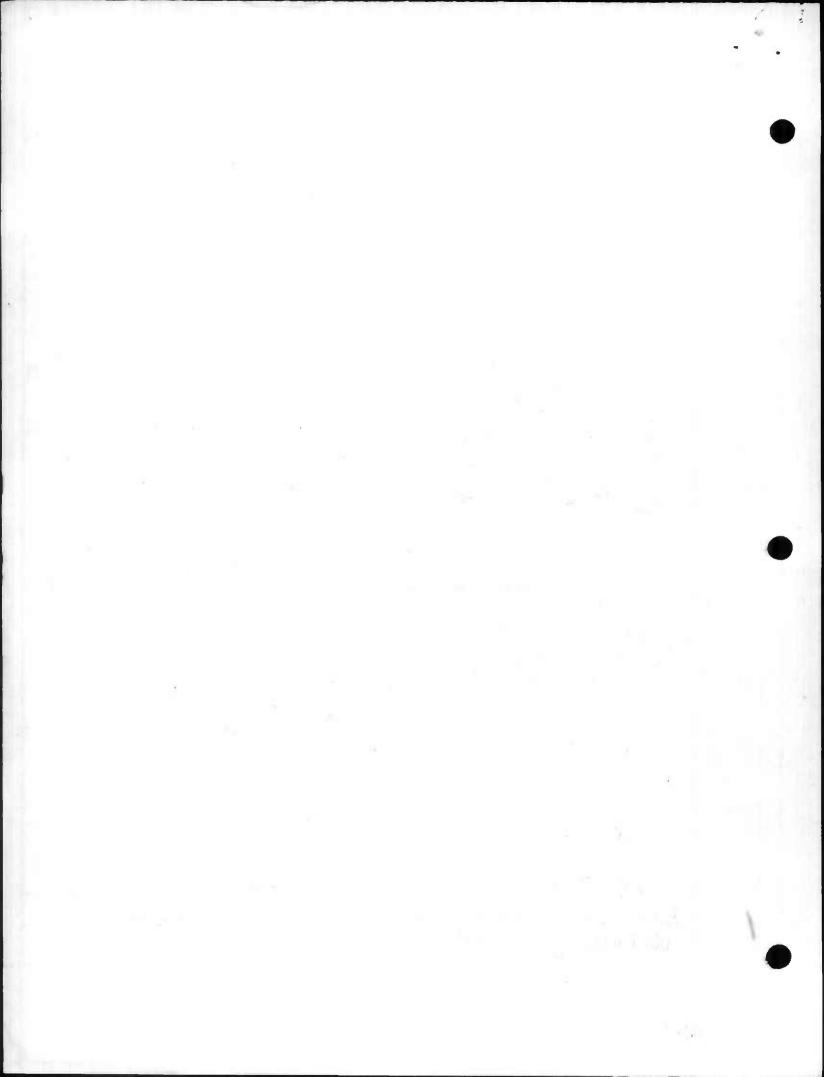
		FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)	DVKeHa	rt s	SR,		2. DATE OF DEATH DO 12	AY 1995	
			6. AGE (In yrs.	YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) March 28,	1931 M	mnPLACE (State or Foreign orty) aryland
	СТОВ	St. Agnes 900 C	2122	9		timore	ATH	9c. COUNTY OF	
	DIRE		imore		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO
Vorial-transk permit. Fages	FUNERAL	1214 Francis A			101	21227			d States
	B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 1 YES 2 2 IF YES, GIVE WAR OR DATES	NO	If yes, sp	ENDENT OF NISPAN ecity Cuban, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	Sp	CE — American Indian, ack, White, atc. ec/ly: hite
	COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade core Elementary/Secondary (0-12)	npleted) Coffege (1-4 or 5 +)	(Give kind of wo life. Do NOT use		perviso		siness/industry	
at once.		17. FATHER'S NAME (First, Middle, Last)		0011	JOIN SU	18. MOTHER'S NA	ME (First, Middle, Malden		-
notified	TO BE	William J. Du				nd Number or Rural F	Pockett Poute Number, City or Tow		21227
2		Madalyn Dukehar 20. METHOD OF DISPOSITION			Franci DISPOSITION (NA		e Baltim	cation - City or	ryland
r must		4 Donation 5 Other (Specify)	GOOK	remetory or other	pard C	emetery	10/14 E		
si examiner		21. SIGNATURE OF EUNERAL SERVICE LICEN	9	li-	Ambr	Sulphu	eral Hom	Road	Arbutus
ljury, or other traumatic event, the madical	CERTIFICATION	23. PART I. Enter the diseases, or comancet, or heert failure. Lis iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OVE TO (OR AS A CONS	EDUENCE OF:	hai (Aschem 2 Dis		ratory arrest,	Approximate interval Between Onset and Death Lew days Many yxs
shows any injury.	MEDICAL	PART II. Other eignificant conditions of Hypertension Multiple My. DID TOBACCO USE CONTRIB	eloma Ce	Depr	ussion me Hear	couse given in 	PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL	ACE OF DEATH	(Check only one)	ONCERIAII			
0	PHYS	27. MANNER OF DEATH	Inpatient 2 ER/Outpatient 26a. DATE OF INJURY (Month, Day, Year)	3 DOA 4	OF 28c. INJ	e 5 ☐ Rasidenca URY AT RK?	8 Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCURED	
is mar	D BY	1 N Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY — At I building, etc. (Specify)		M 1 🗆 1	ES 2 NO	261. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,
If item 28	COMPLETE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	N: To the best of my knowledge, o						
IMPORTANT	8	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of exemination and/o	r investigation,	in my opinion, a	29g. LICENSE NUM			(a) and manner as stated. ED (Month, Day, Year)
IMPO	TO BE	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH AT	EM 27) (7ma P	crimt)	DQ 75	41	* but	12,1995
		GEETHA RAJA	MD. 4367;	Hollin	(Ferry	Rd Suit	(3B, Ba	et, MI	1-21227
		OCT 1 6 1995	32. REGISTRAR'S SIGNATURE						



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
ECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH

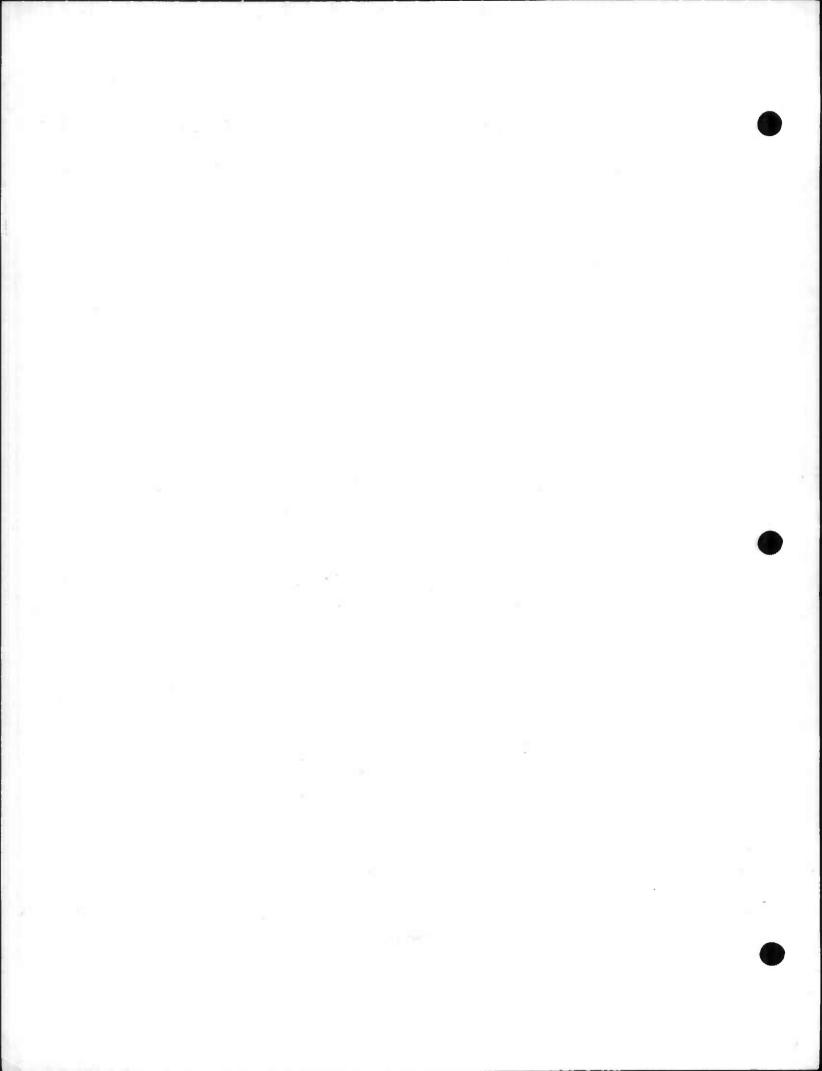
1 - STATE REGISTRAR		SIAIE UF I		ERTIF					WIEN IA	REG. NO			
1. DECEDENT'S NAME (F	rst, Middle, Last)								2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH
Erna			Dahms	ahms				-	Oct. 13, 199			2:50 P.	
4. SOCIAL SECURITY NU		5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER			R 24 HRS.	7. DAT	E OF BIFTH		6. BIRTI	HPLACE (State or Foreign
220-09-0	276	1 M 2 X F	89	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb	nth, Day, Year)	1906	G	ermany
9a. FACILITY NAME (II no					9b. CITY	r, TOWN C		ION OF DE			9c. CO	UNTY OF D	DEATH
Eastpoin	Eastpoint Nursing Home N.A. Baltimore								ore				
Eastpoin RESIDENCE OF D 10a. STATE Maryland 10e. STREET AND NUMB 1046 0 11. MARITAL STATUS 1 Never Married 2				10c. CIT	ry, town	OR LOCAT	ION	_					10d. INSIDE CITY
Maryland	Ba1	timore	N.A.								1 TES 2 NO		
104. STREET AND NUMBE	10e. STREET AND NUMBER							E			10g. CITIZEN OF WHAT COUNTRY?		
1046 0	1046 Old North Point						122				S.A		
3 Widowed 4X D	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4X Divorced 12. WAS DECEDENT E FORCES? 1 FYES, GIVE WAR			YES 22 NO If yes, specify Cuban, Maxic			an, Maxica	in, Puarto Rican, etc.) Black, White			E — American Indian, ik, Whita, etc.		
	ECEOENT'S EDU		16a.	OECEDENT'S				la a		Sb. KIND OF BU	ISINESS/IN	DUSTRY	
Elementary/Secondary		College (1-4 or 5	+)	(Give kind of life. Do NOT u Mach	ise retired.)		ST OF WORK	ing	M	leta1	0 0	- m m -	ny Inc.
8th q		N.A.		Macin	11111	56							ny Inc.
	Middle, Last)						16. MOT	HER'S NA	AME (First	, Middle, Malder	Surname)		
TO INFORMANTIS MANE	unknov	m	1	406 544 0 0 0	2 400000	ė (Ca	and Alice 6			nknow		Plan Phone 1	
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O K S Bra			20h BLAC					, Ru		alto.			CO /
1 Buriai 2 CCreme 4 Donallon 8 Q		oval from Stata	Gre	PLACE AND DATE OF DISPOSITION (Name of telepy, cremetory or other place) Teenmount Cemetery 10-14							e, Md.		
21. BIGNATURE OF TURE		CDISES.						ESS OF FA					0, 110.1
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23. PART of Enter the	out.	June	run		26	3 S	. C	onk.	lin	g St.	Ba1	to.	Md.21224
ahock, or iMMEDIATE CAUSE (disease or condition resulting in death)	heart Millure.	DUE TO	se on each if	ne.	OF):								Interval Between Onest and Deat 4 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								7 day					
PART ii. Other signif	ne contributing to	deeth but no	t resulting	in the u	nderiyin	g Cause	given in	Part I.	24a. WAS AI PERFO	RMED?	Y 241	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIA			C								1		OF DEATH?
DID TOBACCO	USE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗆	NO Z	UN	CERTAI	N□				
25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:	26. PL	ACE OF DEA									
1 YES 2-1 NO		1 Inpatient 2	☐ ER/Outpetient	3 DOA	4 K Nu		6 5 D F	Rasidenca	8 🗆 Ot	her (Specify)			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 28. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 29. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 20. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 21. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 22. WAS CASE REFERRED TO MEDICAL 28. DESCRIBE HOW INJURY OF DEATH (Check only one) 23. WAS CASE REFERRED TO MEDICAL 28. DEATH (Check only one) 24. WAS CASE REFERRED TO MEDICAL 28. DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL 28. DEATH (Check only one) 26. PLACE OF INJURY AT WORK? 10. YES 2. INJURY AT WORK? 11. YES 2. NO 28. DEATH (Check only one) 28. DATE OF INJURY AT WORK? 11. YES 2. NO 28. DEATH (Check only one) 28. DATE OF INJURY AT WORK? 11. YES 2. NO 28. DEATH (Check only one) 28. DATE OF INJURY AT WORK? 11. YES 2. NO 28. DEATH (Check only one) 28. DATE OF INJURY AT WORK? 11. YES 2. NO 28. LOCATION (Street and Number or Rural Route Number or Rur					□ NO	284. DESCRIBE HOW INJURY OCCURED							
					Route Number,								
294. CERTIFIER 1 YC	ERTIFYING PHYS	ICIAN: To the best o	l my knowledge.	death occur	red at the	time, data	and plac	e, and due	e to the c	enuse(s) and m	enner es si	totad.	
(Check only one)													(s) and menner as stated.
	LE OF CERTIFIE	y					29c. LIC	CENSE NU	IMBER		29d. D/	ATE SIGNE	O (Month, Day, Year)
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FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle Last 3. TIME OF DEATH 2. DATE OF DEATH FARLF.E 9 J P 10c7, 10 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign -3449 1 - M 2 F 58 AUG.4. BALTIMORE be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Union Memorial Hospital Baltimore City n/a RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1XXYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 660 E. 27 th STREET 21218 UNITED STATES retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 20 HOUSE IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES NO Specify: BY Specify BABIACK 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY 12 th College (1-4 or 5+) unemployed laborer various trades 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) MOTON BOSTON MYRTLE BE GILLARD funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 MICHAEL LEWIS E. 27 th s treet, baltimore, md uted within 24 hours after death. Page 6 may be a completely filled in by the funeral director, page 5 rial, cremation, or removal. must be 20a. METHOD OF DISPOSITION 1 X Jurial 2 ☐ Cremellon 20b. PLACE AND DATE OF DISPOSITION VOS hell WESTERN 20c LOCATION - Dundalk, MMd DATE 10-17 CATONSVILLE, MD 4 🗆 Donation / 8 🗆 Other 🎮 examiner OF FUNERAL SE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE. medical Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feilure. List only one cause an each line. 23. PART I. Enter the disees Interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death the disesse or condition metabolic resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): executed prior to burial, LIVER - RENZ traumatic CERTIFICATION and Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) attending physician certificate be cause. Enter UNDERLYING We has my lic CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 the death signed by the atte Health and Mental Injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL that апу 1 - YES 2 NO OF DEATN? requires Shows 1 - YES 2 NO peen 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO PHYSICIAN: UNCERTAIN WE Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only or The Hem HOSPITAL: certificate to the State 1 TYES 2 OTHER: ATTENDING PHYSICIAN: etlant 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d, DESCRIBE NOW INJURY OCCURED marked, with a 1 Hatural 5 Pending investigation 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Suicide 90 6 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: after 28 4 Nomicide detarmined hours a Hem ; 8 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL (TO THE FUNERAL CE DE filed within 72 h HOSPITAL On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) mb 9 10/10 95 2 PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Baltmon 42000 32. REGISTRARIS SIGNATURE



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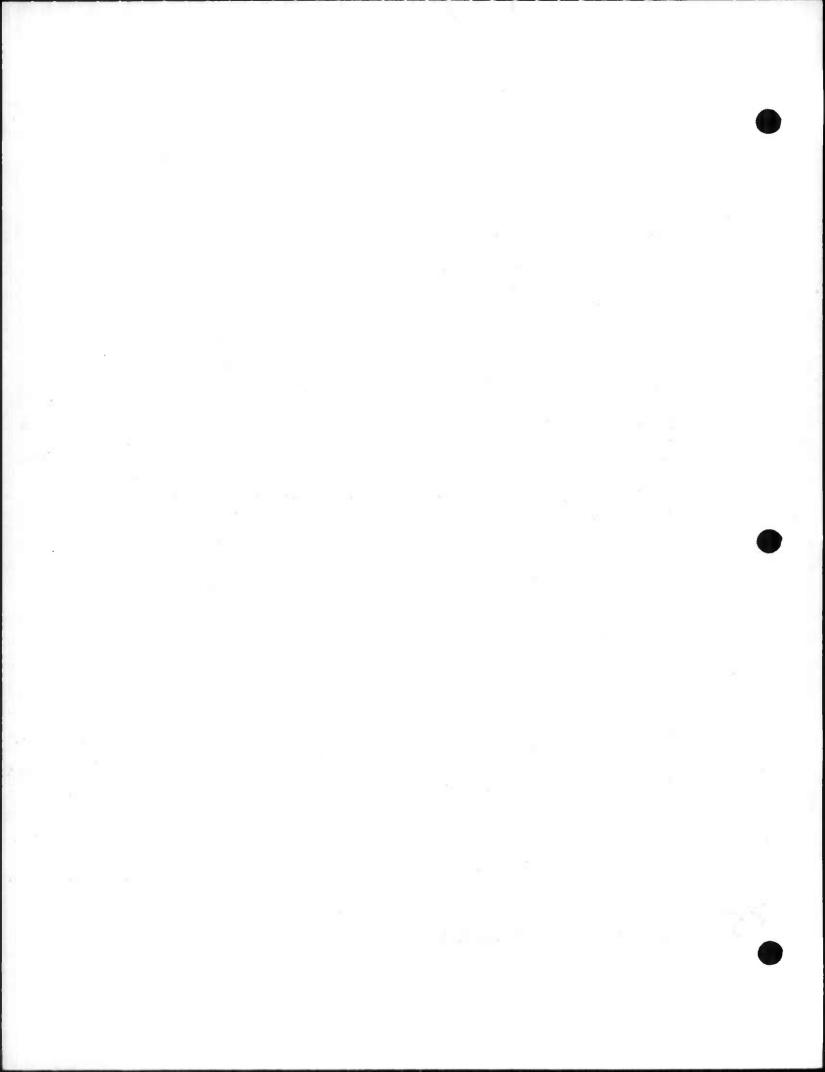
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	BEG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND		GIENE G. NO.	
	1. OECEDENT'S NAME (First, Middle, Lest)					2. DATE OF O	ATN	3. TIME OF DEATH
	WALTER	FREEMAN				OCTOBE		95 5:08 P
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH 8.	BIRTHPLACE (State or Foreign Country)
	126-01-3713	11 2 F	77 YRS. "	DAYS DAYS	HOURS MIN.	JAN.	29-1918	N.Y.
	9s. FACILITY NAME (If not institution, give st	reet and number)	9	b. CITY, TOWN	R LOCATION OF D			Y OF DEATN
DIRECTOR	THE JOHNS HOPKIN	S HOSPITAL		BALTIM	ORE CITY		N	1/A
H H	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION		_	10d. INSIDE CITY LIMITS?
	N. J. M	ORRIS	mo	RRIS	PLAIR	US		1 PYES 2 NO
₫	10e. STREET AND NUMBER		_	101	. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL		BROOK			0795	0		ISA
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF NISPAI	NIC ORIGIN? (Spe	cify Yes or No- 14	I. RACE — American Indian, Black, White, etc.
R	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	res 1	1 TES	2 NO Specif	y:		Specity: WHITE
- 1	15. DECEDENT'S EDUC	ATION	16a, DECEDENT'S US	UAL OCCUPATION	NA CONTRACTOR OF THE PARTY OF T	185 KIND	OF BUSINESS/INDUS	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of wor. life, Do NOT use r	k done durina ma	st of working	100. KIND	OF BUSINESS/INDUS	oini
로		4	ELECTA	ical 1	ENGINE	ERCOI	nmunic	ATION
5	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA			111010
BEC	WALTER C.	FREEMA	N SR.		MAG	LYE	MAC	BUIRE
	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Route Number, Cit	y or Town, State, Zip Co	000) 07950
2	MARGARET F	-REEMAN	17 5	TONO	ey BR	LOOK	MORRIS	S PLAINS N
	20a. METHOD OF DISPOSITION 1. Burlal 2 Cremation 3 Remo		PLACE AND DATE OF		-		20c. LOCATION Cit	y or Town, State
	4 Donation 5 Other (Specify)	ver from suite	tery cremator other		METER	x10/16	MARRIST	TOWNSHIP No.
ı	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22, NAME AP	D ADDRESS OF IA	CILITY	1 6.41	RAL HOME
- 1	010	10/1/10	-		4 NOCE S. High			2/202 MD.
	22 PART I. Enter the diseases, or o shock, or beart failure. I IMMEDIATE CAUSE (Final	omplications that caused lat only one cause on ea	the deeth. Do not ch line.	enter the mo	de of dying, suc	h aa cardlac p	r reapiratory arres	Approximata interval Betwee Onset and Dea
	disease or condition	,	Sancir					2 1
ı	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):					Jours
۱ ۶		I	CONSEQUENCE OF:	Li. Pu	hum F	Shored S		140-0
CALICA	Sequentially list conditiona, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					
3	CAUSE (Disease or Injury							
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
E E	de la contra del la contra de la contra de la contra del la con	i						
ا يُ	PART II. Other aignificant conditions	contributing to deeth bu	t not resulting in	the underlying	ceuse given in	Part I. 24a.	MAS AN AUTOPSY	24b. WERE AUTOPSY FINDING
3	gastnic		diale	2 4	es.	1 1	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						_ ''	YES 2 TNO	OF DEATH?
	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YES		UNCERTAIL			1 TES 2 STATO
Š	25. WAS CASE REFERRED TO MEDICAL		B. PLACE OF DEATH		OTTOLKIAN	1		
3	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpat		THER:	5 Realdence	6 Char (Saus		
ratolcian:	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME C	F 28c, INJ	URY AT		HOW INJURY OCCUP	RED
	1 Natural 5 Pending	(Month, Day, Year)	INJUR		RK? ES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specif	At home, farm, stre	et, factory, office		28f. LOCATION	(Street and Number or	Rural Route Number,
	4 Homicide determined					City or Town	i, state)	
COMPLETED	29a. CERTIFIER Check only	CIAN: To the bast of my knowle	dge, death occurred a	it the time, date	and place, and due	to the cause(a)	and manner as stated	
								rause(a) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	1111			29c. LICENSE NUN			
4	Donn 1	In last			MY.	- S		IGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type Pri	int)	. 02			CTORCA 13/993
	Sanjer	Costat:		rs Ho	10 -	H . 1		
	31. DATE FILED (Mogth, Day, Yogg)	32 REGISTRAR'S SIGNA	URE	× 1 (0)	pich	10050	47	
	OCT 1 6 1995 Ju	led alterder had	AL .					



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remonal. IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAL HYGIEN		
	1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATH
	ROBERT 4. SOCIAL SECURITY NUMBER 5.	Randall		YER Sr	IF UNDER 24 HRS.	OCTOBER 1		5:11 P M
	405-20-7166	× M 2 □ F 68	YRS.	DAYS DAYS	HOURS MIN.	Aug. 19 1	G	w York
œ	9a. FACILITY NAME (If not institution, give street and number)			96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				OF DEATH
DIRECTOR	THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY						1	Las noise or
JIRE	Md. Balti	moro		town or locat xton	ION			10d. INSIDE CITY LIMITS? 1 YES 2 X HO
	10e. STREET AND NUMBER	IIDLE	I NO.		. ZIP CODE		10g. CITIZEH	OF WHAT COUNTRY?
7017 11 1111011101110						USA		
BY FUN	11. MARITAL STATUS 1	P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAT OR DA	U.S. ARMED 2 HO TES	II yes, sp		NIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)		RACE — American Indian, Black, White, etc. Specify: White
	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION	16a. OECEOEHT'S U	SUAL OCCUPATION And Author Michigan		16b. KIHO OF BU	ISINESS/IHDUSTI	
COMPLETED		College (1-4 or 5+)	life. Do NOT use	retired.)	St OF WORKING	Oram	Busines	
OMP	17. FATHER'S NAME (First, Middle, Last)	10	Archi	tect	16. MOTHER'S HA	ME (First, Middle, Malder		55
E CC	Randall Gordan F	ryer				. Burcham	, delinamo,	
TO BE	19a. IHFORMAHT'S HAME (Type/Print)					Aoute Number, City or To-		
-	Adele Fryer	T _{on}	7517			ub Rd. Rus	cation — City	
	20a. METHOD OF DISPOSITION 1	i from Stata	etery cremetory or other Se				wson Mo	
	21. SIGNATURE OF FUHERAL SERVICE LICEH		TTTOP DO		HD ADDRESS OF FA	CILITY		
	Ruck Towson FH 1050 York Rd. 21204							
	23. PART Enter the diseases, oboor shock, or heert failure. Lie			ot enter the mo				Approximata Interval Between
	IMMEDIATE CAUSE (Final			10				Onset and Death
	disease or condition resulting in deeth)	DUE TO (OR AS A	- HRDICAM	apathy				Lypers
z	Coronous artery Disease							
Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
FICA	Cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):							
HTI	that initiated events resulting in death) LAST d.							
	PART II. Other significent conditions	contributing to deeth b	ut not resulting in	the underlyin	g ceuse given in	Part I. 24e. WAS A	H AUTOPSY	24b. WERE AUTOPSY FINDINGS
ICAL		ola C		Brycano		PERFO	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	1778 + 1994. 2) State Port 4th Red B Cold 12 198 10 VES 20 NO OF DEATH?							
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O		NO E	UNĆERTAL	N 🗆		
SICIAN:		INSPITAL:		OTHER:		I Harris Cale		
PHYS	1 YES 2 NO 1 27. MANNER OF DEATH	Inpetient 2 ER/Outs 26s. DATE OF INJURY	26b. TIME	OF 28c. IH	JURY AT	8 Other (Specify) 28d. OESCRIBE HOW	IHJURY OCCUR	ED
	1 Heturel 5 Pending Investigation	(Month, Day, Year)	HJC.		YES 2 HO			
3 Suicide 5 Could not be determined 4 Homicide 5 Could not be determined						t and Number or F	Rural Route Number,	
COMPLET	(Crieck only	AH: To the best of my know On the basis of examination						ruse(s) and manner as stated.
BE	296. SIGNATURE AND TITUE OF SERLIPER	Esera MD			29c. LICENSE HU	MBER 2/8	29d. DAKE SI	GHED (Month, Day, Year) Oley 12 1995
2	PATE L. A. DEVALE	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Carrie	Juny -T	he Johns H	pking Hay	put Paltinus M.
	OCT 1 6 1995	PURES FURNE (SIG)	THE Y		1		4	2128

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Item# 1. G-film 728 per F. H 10/20/95 P.C. STATE OF MARYLAND 7 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BELTON YEAR OCT. 11, 1995 BRADLEY BOLTON GRAY 19:16 P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs, last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 406-78-2889 1∑ M 2 F 36 LOUISVILLE, KY OCT.9,1959 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6890 HAWTHORNE RD. LaPLATA CHARLES RESIDENCE OF DECEDENT 10d. INSIDE CITY 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND LAPLATA 1 YES 2 NO CHARLES FUNERAL 10. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20646 U.S.A 6890 HAWTHORNE ROAD 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married II yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced WHITE COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) BERETTA GUN MANUFACTURING Elementary/Secondary (0-12) College (1-4 or 5+) 1 YR METROLOGY U.S.A. CORP 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS WOOD BELTON B. GRAY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6890 HAWTHORNE ROAD - LAPLATA, MD. 20646 2 SHARON RHODES GRAY 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town. State DATE LOUISVILLE, KY CAVE TTTE CEMETERY 10/14 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. Colema 4107 WILKENS AVENUE- BALTIMORE, MD 21229 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reaplratory arrest, shock, or heart fallure. List only one cause on each line. Approximata interval Batween IMMEDIATE CAUSE (Final Onset and Death Gunshot Wound to Front of Left Chest disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE shows any 1 THES 2 THO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA **EXAMINER?** OTHER: 1 XYES 2 NO 4 - Nursing Nome 5 X Rasidanca 6 - Other (Specify) 0 28b. TIME OF FINJURY 530 P 28e. DATE OF INJURY
(Month, Day, War)
(O) 11 / 95 27. MANNER OF DEATN 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural self-inflicted gunshotwound 5 Pending Invastigation 1 YES 2 NO ВУ 2 Accident
3 Suicide 281. LOCATION (Street and Number or Aural Route Number, Road City or Town, State) 6890 Hawthorne Road 28e. PLACE OF INJURY — building, atc. (Specify) Al home, larm, street, factory, office 60 8 Could not be COMPLETED City or Town. La Plater hours after item 28 is 4 Nomicide Home 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the Ilms, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D Be filed within 72 ho (Check only one) 2XXMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE hufe m Dennis OCT.12,1995 OCME 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

DR. DENNIS J. CHUTE

OCT 1 6 1995

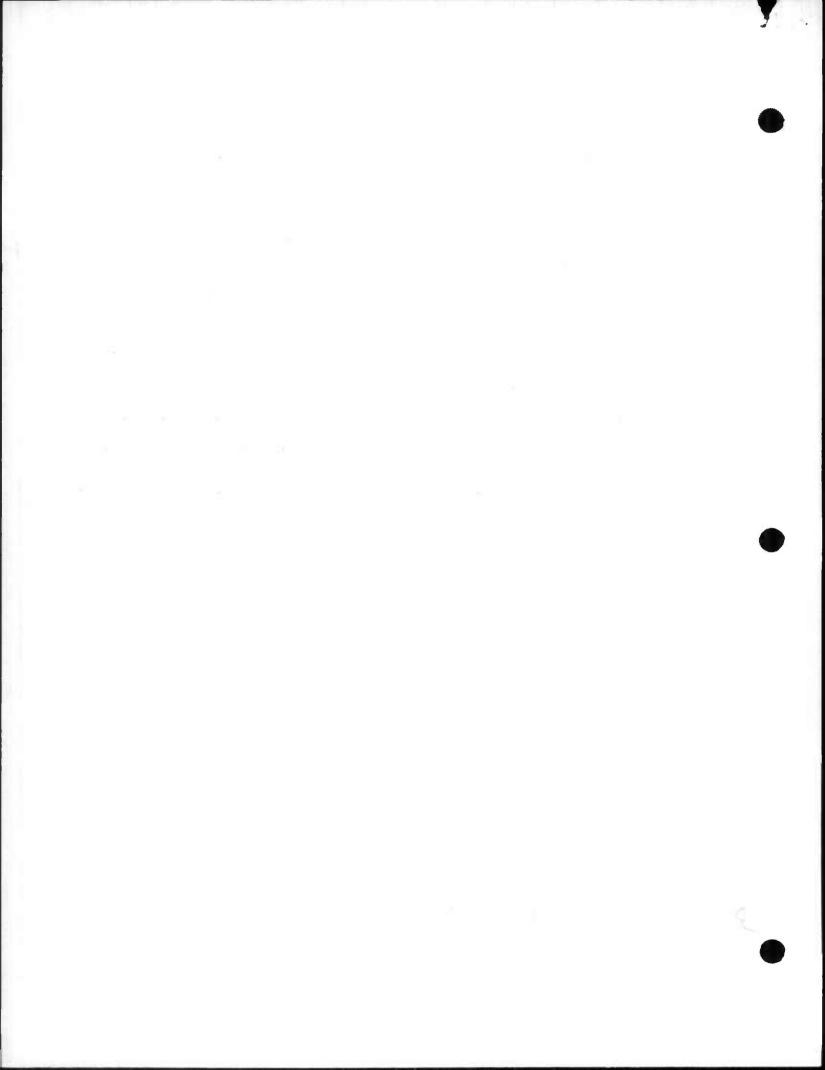
32. REGISTRAR'S SIGNATURE

111 Penn Street, Baltimore, Maryland 21201

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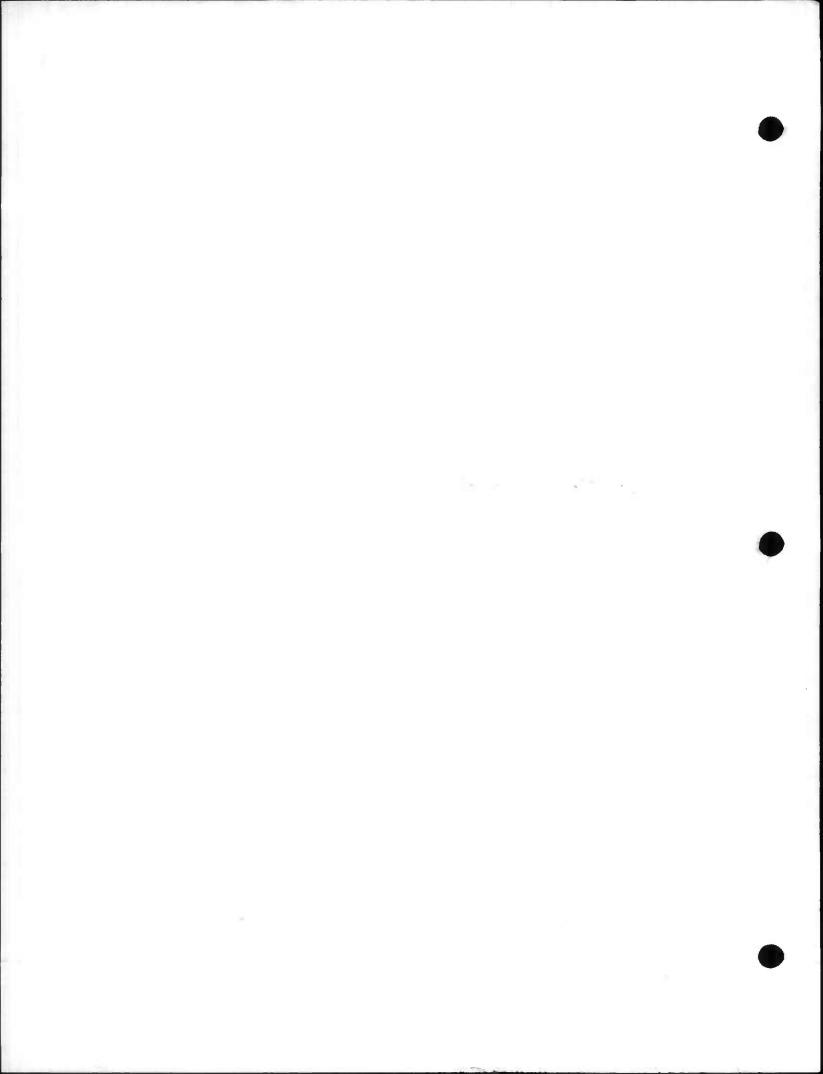
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		HEGIOTHAN					RIJE	CALL	_ 01	DEA			REG. NO	٠.		
		1. DECEDENT'S NAME (First		GEHRING						MONTH	2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH					
		4. SOCIAL SECURITY NUME		5. SEX	6, AGE	(In vrs. last				OCTO:	BER .	13 1	995	02:16 A M		
		215-34-196	7	1 M 2 KX	98		YRS.	MONTHS DAYS HOURS MIN. A			Aug	Day March	1897	Countr	yland	
3 should		Sa. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATION	ON OF DE			9c. COL	JNTY OF D		
2, 3 s	OR	GREATER BA	ENTER	R						ALTI	MORE					
-	ᇤ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY					10c CITY	Z TOWN (20100	TION						
Pag.	DIRECTOR	Md.	Balti	more	ore				10c. CITY, TOWN OR LOCATION Baltimore							10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
permit. Pages	A.	104. STREET AND NUMBER							10	of. ZIP CODE	E			10g. CIT	IZEN OF W	WHAT COUNTRY?
Tist	EH.	6225 York Rd. 21212 USA														
physician, burial-transit	FUNERAL	11. MARITAL STATUS	Mandad	12. WAS DECEDEN	T EVER II	N U.S. ARM	IED	13.	WAS DE	CENDENT C	F NISPAN	NIC ORIGIN	? (Specify Ye	a or No-		— American Indian,
IF YES, GIVE WAR OR DATES 1 YES YOU NO Specify:									Specify: White							
r attending use as the	ETED		EDENT'S EDU			16a. DEC	EDENT'S	USUAL O	CCUPAT	ION	-	16b.	KIND OF BU	SINESS/IN	DUSTRY	
۵ أ	We. E	Do NOT us	e retired.)		iost of working	g		, ,	and a							
the hospital o detached for once.	COMPL	8				BOO.	к ке	eeper					riole		e Co.	
by the	- 18	17. FATNER'S NAME (First, Middle, Lest) John Burke										ME (First, A Taret	liddle, Maiden	Sumama) Keave	าทบ	
5 should	BE	19a. INFORMANT'S NAME (7	19b.	MAILING	ADDRESS	Street				er, City or Tow		_				
	5	Ed Gehring											ton I			
leath. Page 6 may be funeral director, page common must be		20a. METNOD OF DISPOSITE	n 3 🗆 Remo	oval from State		PLACE AN					1.0	DATE	20c. LO	CATION -	City or To	wn, State
Page 6 I direct		Donation 5 Other 21. SIGNATURE OF FUNERAL	_	ENERE C	Inc	TY R	euee						5 Bal	CIMO	re Mo	
death. Pag tuneral di examiner		· 4-1	0 4	50				22.	NAME A		Tov	son				
V 20 10	_	1	1	20	-								. Tow			1204
within 24 hour pletely filed in cremation or remation or rent.		23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) But TO (dR AS A CONSEDUENCE OF): Approximate interval Between Onset and Death 4 months														
Z 2 - 9	Z	C		a												
	CERTIFICATION	Sequentially list conditi if any, leading to imme- cause. Enter UNDERLY!	diate	DUE TO	(OR AS A	CONSEDU	JENCE OF):								
he death certificate be the attending physician Mental Hygiene prior to njury, or other traun	FIC	CAUSE (Disease or inju		DUE TO	(DR AS A	CONSEDU	ENCE OF):								
ending I Hygid	HH	resulting in death) LAS	т	s												
he death he atten Mental H		PART II. Other algolitica	nt condition	s contributing to	death h	ut not res	tulting is	n the un	derivis		duen in	Part I	24s. WAS AN		Low	
uires that the deal signed by the att Health and Menta	EDICAL	CVA	HTN	contributing to death but not resulting in the u			in the underlying cause given in Part (,			rait i.	PERFOR	MED?	240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
signe Healtl		in the second										_	1 TYES 2	. □ NO		OF DEATH?
law requires been bept, of P	ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE O	F DEATI	H YE	S 🗆 I	NO E	UNC	ERTAIN	V 🗆				1 YES 2 NO
N: The la	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	1	26. PLACE)						
1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify)																
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires THE FUNERAL DIRECTOR: After this certificate has been sign filed within 72 hours after death with the State Dept of Healt PORTANT: If Item 28 is marked, or Item 23 shows:	ВУ РНУ		Pending Investigation	28a. DATE OF (Month, D	NJURY ey. Year)		28b. TIME INJU		W	JURY AT ORK? YES 2	NO	28d. DE\$	CRIBE NOW I	NJURY OC	CURED	
ATTENDIR COTOR: At s after de 28 is 1	a	3 Suicide 6 Could not be detarmined 28e. PLACE DF INJURY — At home building, etc. (Specify)						treet, fact	ory, offic	on .		261. LOCA City o	TION (Street in Town, State)	and Number	r or Rural R	oute Number,
RAL DIRE	Conect day															
HOSPITAL FUNERAL WITHIN 72	- 11	29b. SIGNATURE AND TITLE				- minute in	- engation	., my o	риноп, (ing piaca, an			
TO THE HOSPITE TO THE FUNERA DE filed within 7 IMPORTANT: 1	TO BE		6	~	4					29c. LICE	NSE NUM	4110	4	29d. DAT	E SIGNED	(Month, Day, Year)
>		30. NAME AND ADDRESS OF	PERSON WHE	7825	SE OF DE	Or L		Print) E	Pali	t, M	7 7	212	04	,		
5		31. DATE FILED THOTE. 99	93	32 DEGISTA	BES JEW	AS IT IS					_		<u>.</u>			
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) EUGENIA MARIE GUNDINA 2. DATE OF DEATH 3. TIME OF DEATH ENGENIA MONTH YEAR 1124 A 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthdey) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 T 216-03-1425 APR 23, 1908 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bon Secours Hospital Baltimore N/A 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A YES 2 NO Baltimore FUNERAL 10f. 7IP CODE 10a, CITIZEN OF WHAT COUNTRY? 1529 Poplar Grove Street 21216 USA 24 hours after death, Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burlat-tran 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Mexican, Puerto Rican, etc.)
 \(\sum_{YES} 2 \) NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Clerk Retail Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles 76 Vernon Gundina Geanne Dalby BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Ellen L. Dix 1014 Circle Drive Eldersburg, MD 21784 Pe 20a. METHOD OF DISPOSITION
t
Burial 2 Cremation 3
R 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Metro Crematory, Inc. 10/14/95 Baltimore,

22. NAME AND ADDRESS OF FACILITY
Cremation Society of Md., Inc. 4 Donation 5 Other (Specify) Baltimore, MD examiner filled in by the funeral on, or removal. George E. MacNabb 299 Frederick Rd. Balto., MD 21228 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final cremation, traumatic event, the disease or condition_ 1 who completely resulting in death) executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760, and com o burial, o years CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF attending physician armal Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING certificate be L CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 0 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death the atten PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Health and has been signed by the Dept. of Health and m 23 shows any in luri t TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) s certificate h Hem HOSPITAL: OTHER: 1 - YES 2/5 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? this c 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 2 Accident 5 Pending Investigation t YES 2 NO After the BY 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) DIRECTOR: A hours after de litem 28 is 60 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. MPORTANT: II 29d. DATE SIGNED (Month, Day, Year) BE 포포 DZ 6 256 2 8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B1 CH 700 Washindon DUONG 32. REGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within \$\times\$ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

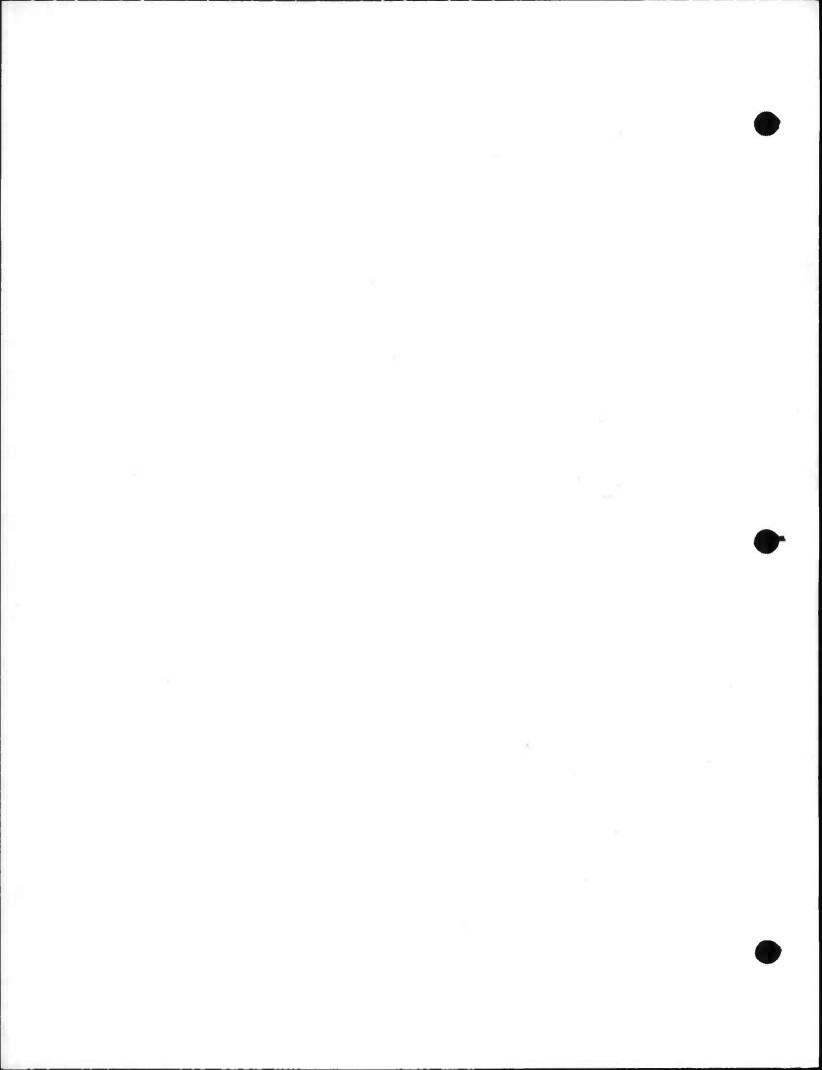
FOR

	1 - STATE REGISTRAR		ICATE OF	DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH D	AY YEAT	3. TIME OF DEATH				
	SHEILA I HEALEY	,			OCT 1						
- 1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. last birtnday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. Bi	RTHPLACE (State or Foreign untry)				
	214-62-5973	40 YAS.	MONTHS DAYS	HOURS MIN.	SEPT. 24,		MARYLAND				
	9a. FACILITY NAME (If not institution, give street and number)		96. CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNTY O	F DEATH				
DIRECTOR	ST. AGNES HOSPITAL		BALT	TMORE		N/A					
E	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?				
<u>=</u>	MARYLAND N/A	BA	LTIMORE				1 X YES 2 NO				
AL	10e. STREET AND NUMBER		101	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY					
E	2547 ASHTON STREET			21223		U.S.A.					
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2XX Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 XNO	It yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 X NO Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 17. FATHER'S NAME (First, Middle, Last) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refined.) HOMEMAKER 16b. KIND OF BUSINESS/INDUSTRY (Give kind of working life.) HOMEMAKER HOME 18. MOTHER'S NAME (First, Middle, Maiden Sumame)							Υ				
MP	11	HOMEN	1AKER		НО						
8	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden	Sumame)					
BE	WILLIAM HENRY WARD			AGNES	SICKLE						
2	19a, INFORMANT'S NAME (Typo/Print)				Route Number, City or Tov						
	JAMES P. HEALEY 20s. METHOD OF DISPOSITION 20	b. PLACE AND DATE			BALTIMORE,	CATION — City o	223				
		OUDON PAI					, MARYLAND				
	21. SIGNATURE OF LUCENAL VERNICE LICENSES	OUDON IAI		ID ADDRESS OF FA		LILIORE	, PARILAND				
	> 1/0il & Viso -				FUNERAL HO AVENUE, B						
	23. PART I. Enter the diseases, or complications that cause						Approximate				
	ahock, or heart feliure. List only one cause on IMMEDIATE CAUSE (Final		0.00.00 13				interval Batween Onset and Daeth				
	disease or condition a. CANCER		LARYN	*			3 months				
_	DUE TO (OR AS	A CONSEQUENCE C	OF):								
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	if any, laading to immediate cause. Enter UNDERLYING										
FIC	CAUSE (Disease or injury that initiated events	A CONSEQUENCE C	OF):								
H	resulting in death) LAST										
	PART II Oh a stanilland and like a said half a dad	L.A A 101	1. 1.		B. 41 A						
PHYSICIAN: MEDICAL	PART ii. Other aignificant conditions contributing to death	but not reaulting	in the underlyin	g cause given in		PERFORMED? AVAILABLE S					
DIC					1 TYES	2 NO	COMPLETION OF CAUSE OF DEATH?				
M		OF DEATH V	TO [] NO [I INTERPATE			1 YES 2 NO				
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE		ES LI NO L	UNCERTAI	N L J						
0	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		OTHER:								
ΙΥS	1 YES 2 TONO 1 TON TON THE PROPERTY OF THE PRO				6 Other (Specify) 26d, DESCRIBE HOW	IN ILIEN OCCUPE	0				
	1 Netural 5 Pending (Month, Day, Year,		JURY WO	YES 2 NO	200, DESCRIBE NOW	INJUNI OCCURE					
2 Accident Investigation 26a PLACE OF INLIESY At home term street fectors office. 26t LOCATION (Street and Number or Burni Re-											
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined)									
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kno	owledga, death occur	red at the time, date	and place, and due	a to the cause(a) and me	nner as stated.					
MO	one) 2 MEDICAL EXAMINER: On the besis of examinat	ion and/or investigati	ion, in my opinion, a	faath occured at the	time, data and placa, a	nd dua to the cau	se(a) and manner as stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU		29d. DATE SIG	NED (Month, Day, Year)				
8E	HOUSE O	FFI WIL.		D 45	157	► 8C	13,1995				
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Typ	e, Print)	- 618 .10	or SPRIO	· ~	ا ٢٥٥٥٢.				
	TIN OO MANNY & FATT	SNATURE	77790 0	SICOL	211.10	1 / 1	ب بحرامه				
	OCT 1 6 1995 July 3 REGISTRAR	Mall									

* *

FOR STATE

		REGISTRAR		CERT	IFICATE OF	DEATH	REG. NO	0.	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY Y	3. TIME OF DEATH
	1 1	VETA MAY HUSBAN	ID				OCTOBER 1		4:58 AM
	П			(In yrs. last birth	day) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	0.	BIRTHPLACE (State or Foreign Country)
9		223 00 3023	1 M 2 X F	81 YF	IS. MONTHS DAYS	HOURS MIN.	JULY 24,	1914	JAMAICA
pinous	_	an. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	
6,	СТОВ	GOOD SAMARITAN HO	SPITAL		BALTI	MORE		N/	A
es 1	1 W I	10a. STATE 10b. COUNTY		10c	CITY, TOWN OR LOCA	TION			10d. INSIDE CITY
r. Pages	E	MARYLAND N/A			BALTIMOR	RE			LIMITS?
permit.	4	10e. STREET AND NUMBER				1. ZIP CODE		10g. CITIZEN	N OF WHAT COUNTRY?
75	FUNERAL	6401 LOCH RAVEN B	OULEVARD			21239		U.S	S.A.
020 physician. burial-transit	15		t2. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Y		. RACE — American Indian.
	BY F	1 Never Married 2 Married 3XX Widowed 4 Divorced	IF YES, OIVE WAR OR	DATES		NO Speci	an, Puerlo Rican, etc.) fy:		Black, White, atc. Specify:
endin as th	ED B	15. DECEDENT'S EDUCA	7101						BLACK
or atte	ETE	(Specify only highest grade co	ompleted)	(Give kin	NT'S USUAL OCCUPATION of work done during mo OT use retired.)		16b, KIND OF B	USINESS/INDUS	TRY
NU 21215-0 hospital or attending ached for use as the	P. E.	Elementary/Secondary (0-12)	College (1-4 or 5+)		STRESS		CLOTH	ING STO)RE
the hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Last)			J11000	16. MOTHER'S N	AME (First, Middle, Maide		7.7.2
a ga	l w l	JOHN TULLOCH				HILDA	CALDWEL		
T R R	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAI	LINO ADDRESS (Street a		Route Number, City or To		ide)
5 5 0 5	2	GLORIA V. WERTZ		461	8 NORTHWO	DD DRIVE	, BALTIMOR	E. MARY	YLAND 21239
may be		20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remove	ml from State	b. PLACE AND D.	ATE OF DISPOSITION /N	ame of		OCATION - City	
D of E		4 Donation 5 Other (Specify)		LOUDON	PARK CEME	TERY 10	/14/95 B	ALTIMO	RE, MARYLAND
ALLIM death. Page thread directly.		21. SIGNATURE OF FUNERIO, SERVICE LICEN	KDEE /			ND ADDRESS OF FA	CILITY		
death e fune exam		► 7/01 E	PIIO	_	3620	UTIPENC	FUNERAL HO AVENUE, B	ME, INC	C. RE, MD 21229
by the or removal.	10.0	23. PART I. Enter the diseases, or col	mplications that cause	d the death.	Do not enter the mo	de of dying, suc	ch as cardlec or res	piratory screat	t, Approximate
DO DO E		shock, or heart fellure. Lie IMMEDIATE CAUSE (Final	at only one cause on	esch line.		4			Interval Between Onset and Death
2 = 6 B		disease or condition	(DPD)	VASC	CAL.	collas	120		140
		resulting in death) a.	DUE TO (OR AS			-	400		1 INC
executed and con o burial, or matic en	z		Corer	M	ARGR	Pm	O CLASE		
	[일	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEQUENC	E OF):	- 1.0	7 - 0 - 10		
cate be othysicial by prior e prior or trau	2	CAUSE (Disease or Injury	171428	SAC!	Parli	iw			
certificate nding physi Hygiene pr	E	that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENC	E OF);				
7 = 2 - 9	CERTIFICATION	d.							
그 를 흔들 글	CAL	PART II. Other aignificent conditions	contributing to deeth	but not result	ing in the underlyin	g ceuse given in	Part I. 24s. WAS A	N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS
any led by	임							2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires seen sign of Heal	WE								1 VES 2 NO
law re law re as bee Dept. o	ا ج	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	OF DEATH	YES NO	UNCERTAI	N 🗆		
The The	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	DEATH (Check only one)				
SICIAN: The certificate the State (, or Item	IS	1 TYES 2 K NO	t Kinpetient 2 - ER/Out	petiant 3 DC	OTHER: 4 Nursing Horr	e 5 🗆 Rasidence	8 Other (Specify)		
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the Sb 1 28 Is marked, or It	РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	26b.	TIME OF 28c. INJ	URY AT PRK?	28d. OEŞCRIBE HOW	INJURY OCCUR	EO
After this death with	βÁ	2 Accident Investigation				YES 2 NO			
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	8	3 Suicide 6 Could not be 4 Homicide delermined	28e. PLACE OF INJURY building, atc. (Spe	Y — At homa, la ecify)	rm, street, factory, offic	•	261. LOCATION (Street City or Town, State	and Number or F	Rural Route Number,
OR ATT DIRECT hours at	ᇤ								
4 4 2 m	MPL		AN: To the beat of my know						
HOSPITAL FUNERAL within 72 h	S	2 MEOICAL EXAMINER:	On the beels of examination	on and/or Investi	gation, in my opinion, d	leath occured at the	time, date end place, a	ind due to the ce	euse(a) end manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	w II	290. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE SI	IGNED (Month, Day, Year)
5 5 8 W	TO B	manom ?	, mous	*		NSA	148	10	1-1-10
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR	A W	Type, Print)	L W.1	EUGENI A	NE #6	5 BALT No
_		31. ODCT 106 1995 Jul	32) EGS [ALS]	WALL .					



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

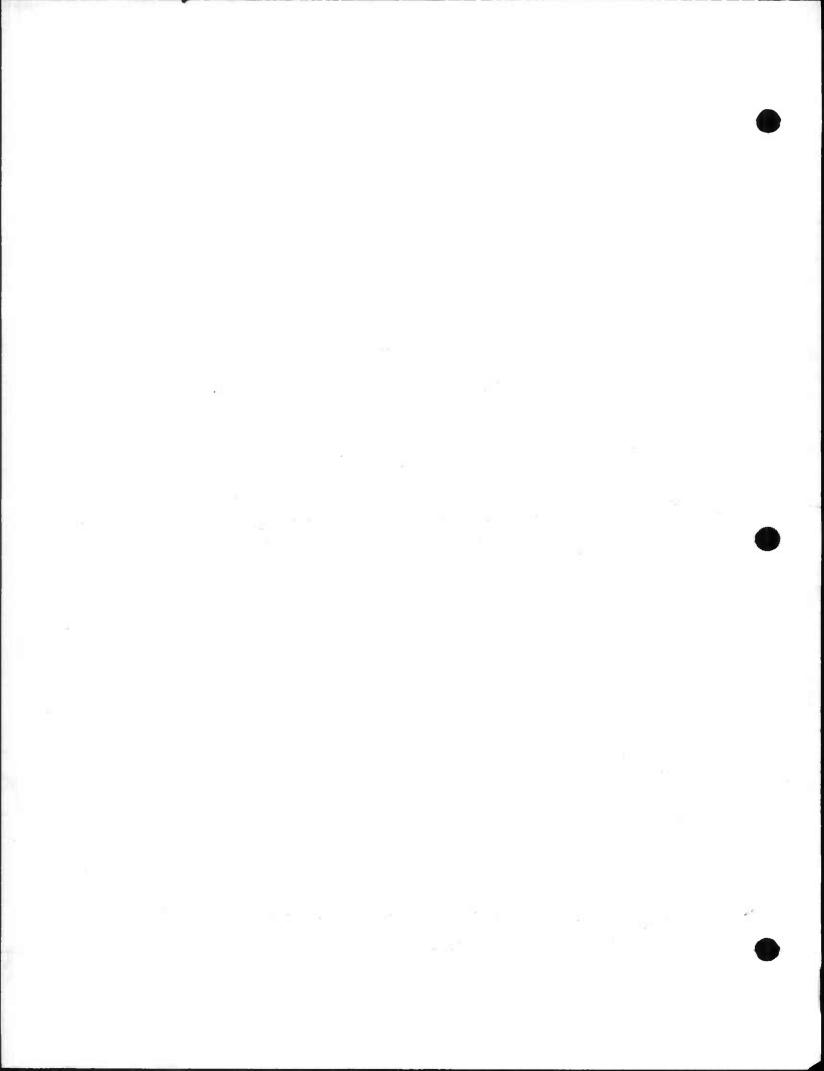
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN	_	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY YEA	3. TIME OF DEATH
Subrena Mac	9	Harper	_	Oct. 9		
4. SOCIAL SECURITY NUMBER 233-11-2125	5. SEX		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	APR. 3, 1	965 WE	RTHPLACE (State or Foreign Unitry) ST VIRGINIA
9a. FACILITY NAME (If not institution, give str	. ,	96	CITY, TOWN OR LOCATION OF		9c. COUNTY O	F DEATH
	HOSPICE		TOWSON, MD		BAL	.TIMORE
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, TO	OWN OR LOCATION			10d. INSIDE CITY
MARYLAND	n/a		BALTIMORE 100, ZIP CODE			LIMITS?
-21117.0020 200 200 200 200	'ENUE		21218		UNITE	D STATES
11. MARITAL STATUS	12 WAS DECEDENT EVED I	N U.S. ARMED	13. WAS DECENDENT OF HISP	ANIC ORIGIN? (Specify Ye		ACE — American Indian,
						lack, White, atc.
15. DECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	16a. DECEDENT'S USU	JAL OCCUPATION done during most of working	16b. KIND OF BU	SINESS/INDUSTR	Y
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)			
9 th		LABORE				ades
	PER JR.			IAME (First, Middle, Maiden	Sumame)	
19a. INFORMANT'S NAME (Type/Print)	TLK UK.	AND MAILING AND	DRESS (Street and Number or Rura		Although and	
REGINA HARPE	R	2136		S T., BALTI		
200 METHOD OF DISPOSITION	200	. PLACE AND DATE OF D	ISPOSITION (Name of		CATION — City of	
1 🗷 Surfal 2 🗆 Commation 3 🗆 Remort 4 🗆 Donation 🔰 🔾 Other (Specify)	vei from State cen	KING MEM	ORIAL PARK	1 1 1 1	NDALLST	
21. SIGNATURE OF UNERAL SERVICE LICE	HAR STAR	ILLE	WM. C. MARCH	FACILITY		
23. PART (, Enter the diseases, or co	ortplications that cause	d the death. Do not	entar tha mode of dying, au	ich as cardiac or resp	fratory arrest.	APPROXIMATE
ahock, or haart fallura. L IMMEDIATE CAUSE (Final	ist only one cause on e	ach lina.			2000	Interval Between Onset and Death
Alle and the state of the state	Acquired I	mmune Defi	ciency Syndro	orge		18 Months
resulting in Geath)		CONSEQUENCE OF):	1 1			
Sequentially list conditions, b.						
If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):				
CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF:				
resulting in death) LAST		,				
PART II. Other algnificant conditions	contributing to death b	ut not reaulting in ti	ne undariying causa given i	n Part I. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
				1 _ YES	NO	OF DEATH?
DID TORACCO HIST CONTR	INLITE TO CALICE O					t TYES 2 NO
DID TOBACCO USE CONTR	IBUTE TO CAUSE C	26. PLACE OF DEATH (IN []		
	HOSPITAL:	01	THER: Nursing Home 5 Realdence	37 ou	TT '	
27. MANNER OF DEATH	284 DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW	HOSPICE	
1 Natural 5 Pending Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES 2 NO			1.0
3 Suicide 8 Could not be	88a. PLACE OF INJURY building, stc. (Spec	— At home, tarm, stree	t, factory, offica	281. LOCATION (Street City or Town, State)	and Number or Rur	al Route Number,
4 Homicide detarmined				City or lown, State)		100
29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge, death occurred at	the time, data and place, and du	ra to the cause(a) and me	nner as stated.	
			my opinion, death occured at th			e(a) and mannar as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER			29c, CICENSE NI	JMBER 50 fg		DED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Prin	0			
Eddie Nakhuda, M.	D. 2300 Du	laney Vall	ev Road, Tows	son, MD 21	204	
OCT 1 6 1995 A	1 develor Re	alall.				



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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	RTMENT	OF H	EALTH DEAT	AND N	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	is Ileah			-			2. DATE	OF DEATH	-	YEAR	3. TIME OF DEATH
		SEX B. AGE (In	ure fact hirthday)	is twosp i	VEAR	IT IMPER	04.1000		stoper/c	٨.,	95	5 an H
	215-50-9094	-50-9094 1 M 2 M F 104 VRS. MONTHS DAYS HOURS MIN. SEPT 24, 1891 DELTAY								PLACE (State or Foreign Y) CAVILLE, VA		
O.B.	90. FACILITY NAME (If not institution, give stree FALLSTON GENERAL H			9ь. сіту, FAL			ON OF DE	ATH			NTY OF D	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			Y, TOWN OF								
DIRECTOR	MARYLAND BAL	TIMORE	100, 011	T, TOWN OF		LTIMO	RE					10d. INSIDE CITY LIMITS? 1 YES \$\int \text{NO} NO
FUNERAL	100. STREET AND NUMBER 915 WILTON DRIVE				10f.	212	_			10g. CITI	U.S.	WHAT COUNTRY?
<u>S</u>	11. MARITAL STATUS 13	. WAS DECEDENT EVER IN U	J.S. ARMED	13. W	AS DEC	ENDENT O	F HISPANI	IC ORIGIN	7 (Specify Yes	or No	14. BACE	- American Indian.
BY F	3 1 Wildowed 4 □ Divorced IF YES, GIVE WIAR OR OATES 1 □ YES 2 1 NO Specify: Specify:							k, White, etc.				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY												
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) HOMEMAKER HOMEMAKING								JC.			
NO.	17. FATHER'S NAME (First, Middle, Last)		1101			16. MOTH	IFR'S NAM	AF (First I	Aiddle, Maiden		ицст	10
	JOHN TRADE						GRE			Surname)		
38 0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	(Street e	nd Number	or Rural A	oute Numb	oer, City or Town	n, State, Zip	Code)	
으	JAMES P. HART		9337 1	ILLB:	ROOF	K ROA	AD -	ELL	COTT	CITY,	MD	21043
	20s. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I from State 20b. P	LACEAND DATE	of DISPOSIT	rion (Nai METI	ne of		10/		CATION (wn, State
	21. SIGNATURE OF FUNERAL SERVICE LICENS		7	22. N	AME AN	D ADDRES	S OF FAC	ILITY			7712	
	M. Tleas	Molomo	m	41	07 T	JILKE	ENS A	VEN	OME, I JE-BAL	TIMOF	RE, N	⁄D 21229
	23. PART I. Enter the disesses, or comehock, or haert fallure. List	plicetions that ceused to only one ceuse on asc	ha death. Do r	not enter t	he mod	de of dyl	ng, such	ss card	lec or respi	ratory srr	eat,	Approximats Intervel Between
	IMMEDIATE CAUSE (Final disease or condition	Caria										Onset and Death
ŀ	resulting in death) s	DUE TO (OR AS A C	ONE CUENCE O									
,		DEHVDE	VAT10									i 1
	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	1	F):								
2	CAUSE. Enter UNDERLYING CAUSE (Disease or Injury	CONGEST	IVE		A	77	FA	11/1	JRE			
CERTIFICATION	that initisted events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	F):								
	d											
¥	PART II. Other aignificent conditions c	ontributing to death but	not resulting	n the und	lerlying	cause g	Iven in F	Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
: MEDIC								- 1	1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?
ž	DID TOPACCO LICE CONTRIB	LITE TO CALLES OF						_		1		1 YES 2 NO
Ž V	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT			UNC	ERTAIN					
PHYSICIAN		OSPITAL:		OTHER:		s □ 0:	aldana la		(Dr M.)			
ξH	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. T/M	E OF 2	28c. INJU	IRY AT	_			JURY OCC	URED	
Colly or Town, Stete Colly or Town, Stete												
							loute Number,					
MPLET	290. CERTIFIER 1 CERTIFYING PHYSICIAL	: To the best of my knowled	na deeth coours	el el the time	a deta							
COM		on the basis of examination e										end manner se stated.
w III	296 SHOMATORE AND THE OF CERTIFIER		/ -			29c. LICE	NSE NUME	BER		29d. DATE	SIGNED	(Month, Day, Ybar)
9 0	- WINT	MON	NI	<i>X</i> O		H4	-101	69		1	0/12	2/95
	STANLEY M. KM	MPLETED CAUSE OF DEATH	_		h	Who	v #	100	E	dge u	Ionol	HD ZINYA
	31. DAY (4 FP (Month 6 7995 Jul	32. DEGISTRAR'S SIGNATI		(1)	/ Y	TOPS	1	102		A ye ii	JUEG	110 21070
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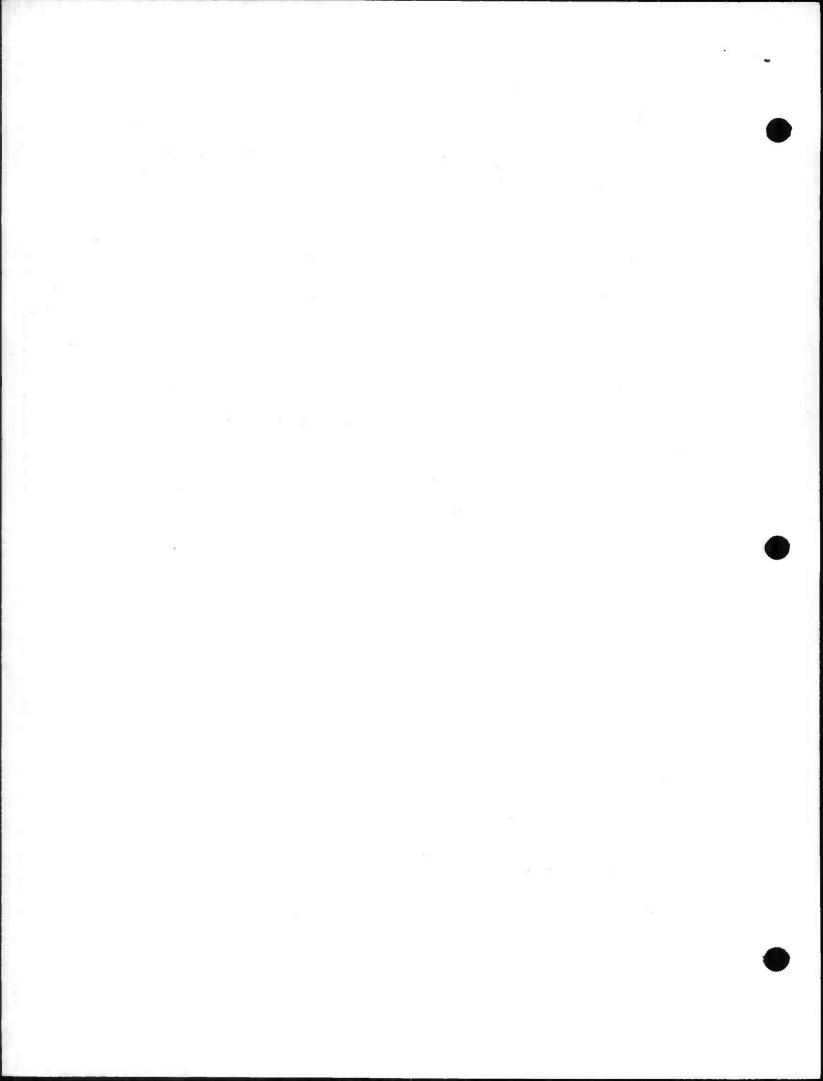
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND / DEP CERT	PARTMENT O	F HEALTH AND	MENTAL HYGII					
1. DECEDENT'S NAME (First, Middle, Last) LEANDER		HOLLAN	ND		2. DATE OF DEATH MONTH OCT. 1	1°, 199°5	3. TIME OF DEATH 9:43 P. M			
4. SOCIAL SECURITY NUMBER 216-34-9686	5. SEX 1 M 2 F	6. AGE (In yrs. last birtho	(ay) IF UNDER 1 YE MONTHS DA	AYS HOURS MIN.	7. DATE OF BIRTH (Morth, Dey, Year) (Ac 7, 1937 8. BIRTHPLACE (State or Foreign Country) (Country)					
ST. AGNES HO										
	VIA	10c.	CITY, TOWN OR L	101. ZIP CODE		10g, CITIZEN OF	10d. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTRY?			
10. STREET AND NUMBER 222 11. MARITAL STATUS 1 Never Married 2 Mistried	FORCES? 1	IT EVER IN U.S. ARMED	If ye	DECENDENT OF NISPA	an, Puerlo Rican, etc.)	Yee or No — 14. RAI Ble	CE — American Indian, ck, White, etc.			
3 Wildowed 4 Divorced 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind	NT'S USUAL OCCU d of work done durin DT yes retired.)	PATION		BUSINESS/INDUSTRY	Black			
Elementary/Secondary (0-12) TI FATHER'S NAME (First, Middle, Last)	College 1-4 or 5	" Sel	((ployed 18. MOTHER'S N.	AME (First, Middle, Mak	den Sumanie)	ing			
19. INFORMANT'S NAME (Type/Print)	ote.	ind 27	LING ADDRESS (S	Poly and Number or Ruel	Plens Number City or	Town, State, Zip Code)	1 21216			
209 METHOD OF DISPOSITION Buriel 2 Cremation 3 Ram 4 Donation 6 Other (Specify)		20h PLACE AND D	ATE OF DISPOSITION OF Other place)	100		LOCATION - CHY OF	0 1			
21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	2000	22. NA	ME AND ADDRESS OF F	abash	Ave				
23. PART I. Enter the diseases, or shock, or heart feliura. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ce	et caused the desth. use on each line. OSCIETOTO OR AS A CONSCOURN	ic CAK	e mode of dylng, su	ch as cardisc or re		Approximata Interval Batween Onset and Death			
Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	c.	OR AS A CONSEQUENCE								
resulting in deeth) LAST	d									
PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceues given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DEA							No. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
	RIBUTE TO CA				IN 🗆					
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XYES 2 NO	HOSPITAL:	26. PLACE OF	OTHER:	Nome 5 Reeldence	e [] Oh (C					
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28a. DATE O		TIME OF 28	ic. INJURY AT WORK?		DW INJURY OCCURED				
3 Suicide 8 Could not be 4 Nomicide detarmined	28s. PLACE (building	OF INJURY — At home, to , atc. (Specify)	orm, street, factory	, office	281. LOCATION (Str City or Town, S	eet and Number or Rura tate)	I Route Number,			
one) 2 MEDICAL EXAMINI	ER: On the thesis of	f my houseledge, death or					e(e) and manner se stated.			
30. HAME AND ADDRESS-OF PERSON WE	Ball	JSE OF DEATH (ITEM 27)	(Type Print)	O . C . M		29d. DATE SIGNI ▶OCT .	12, 1995			
MARIO + GO		· · · · · · · · · · · · · · · · · · ·		treet R	altimore	. Marvla	and 21201			



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		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H			GIENE 3. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)	Jessie A.	. Hear:	n		2. DATE OF DE MONTH OCT		3. TIME OF DEATH 5:40 A M
pin		220 72 7004	1 □ M 2 😿 F	n yrs. last birthday) 82 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day, JUL 10	TH (Nar)	BIRTHPLACE (State or Foreign Country) Virginia
1, 2, 3 should	стоя	90. FACILITY NAME (If not institution, give street and the street				TOWSON	EATH		Baltimore
permit, Pages	DIRE		Baltimore	10c. CITY	, TOWN OR LOCA		imore	Á	10d. INSIDE CITY LIMITS? 1 YES 2 X NO
150	NERAL	10e. STREET AND NUMBER 722 Overbrook R 11. MARITAL STATUS				f. ZIP CODE 212			USA
	BY FUN	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, OIVE WAR OR DA	2 X NO	If yes, sp	CENDENT OF HISPAI Decify Cuban, Maxica 3 2 NO Specif	in, Puarto Rican, a	offy Yes or No — 1 ric.)	4. RACE — American Indian, Black, White, atc. Specify: White
2127 Zal or atte for use a	TO BE (15, DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		Ille. Do NOT use	rork done during mo e retired.)	ost of working	16b. KIND	OF BUSINESS/INDU	STRY
the hospital detached to		17. FATHER'S NAME (First, Middle, Last)			memake:	_	ME (First, Middle, i	Home	
ALIIMOKE, MAKYL death. Page 6 may be retained by the funeral director, page 5 should be e		Sylvester 19a. INFORMANT'S NAME (Type/Print)	Joseph A	Allen 196. MAILINO	ADDRESS (Street a	and Number or Rural		Gardner or Town, State, Zip C	
		Ridia E. Busick	20b.	PLACE AND DATE O	FDISPOSITION (NE	rke Ave		OWSON,	MD 21286 ty or Town, State
		4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE LIBE	Me	etro Crer	natory,	Inc. 10/ ND ADDRESS OF FA	CILITY		Tnc
y the	Н	George E. M		the death. Do no	299	Frederi	ck Rd.	Balto	MD 21228
within 24 hour pletely filled is cremation, or rent the me		immediate cause (Final	Metasta	ich line.	Dive	, dis		Traphatory 21100	Interval Between Onset and Death
certificate be executed fing physician and con ygiene prior to buriat, other traumatic er	ERTIFICATION								
at the d by the and Me	EDICAL CE	PART II. Other algnificant conditions	contributing to deeth bu	ut not reaulting in	n the underlyin	g cause given in	P	AS AN AUTOPSY ERFORMED? VES 2 M NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law req as been bept. of	N.	DID TOBACCO USE CONTRI				UNCERTAIL	N D		1 _ YES 2 _ ND
E as a E	YSICIA	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpe	etient 3 DOA	OTHER:	ne 5 🗆 Rasidence	8 Other (Special	(y)	
F ta ta	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	M 1 1	PRK? YES 2 NO	28d. DESCRIBE	HOW INJURY OCCU	RED
TTENDII TTENDII ATTENDII Atten de	0	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, stc. (Special	— At home, farm, st	reet, factory, offic	•	28f. LOCATION (City or Town	Street and Number or State)	Rural Route Number,
₹ 4 K ₩	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI. 2 MEDICAL EXAMINER:	AN: To the beat of my knowle On the beats of examination	edge, death occurred and/or investigation	d at the time, data	and place, and dua leath occured at the	to the cause(s) at time, data and plo	nd manner as stated	i. cause(s) and mariner as stated,
TO THE HOSPI TO THE FUNER be filed within	TO BE C	295. SIGNATURE AND TITLE OF CERTIFIER	2.4/1	1c. 1	0	29c. LICENSE NUI		29d. DATE S	BIGNED (Month, Day, Year) T 14, 1995
6		Michael K. Ro,		Harfor				MD 212	34
		ULI 1 6 1995 jul	32, REGISTRAR'S SIGNA	TURE			111111111111111111111111111111111111111		



FOR STATE REGISTE
t. DECEDENT'S
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4. SOCIAL SEC
219-5
9a. FACILITY N
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAN CENTIFICATE OF BEATH	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest) ROSCOE Jackson Jr.	2. DATE OF DEATH MONTH DA	10 0 70 1 0 0 0 0						
	4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTH	8. BIRTNPLACE (State or Foreign						
	719-59-9087 1XM201 73 VAS.	1	1950 md						
OR	9a. FACILITY NAME (If not institution, give street and number) University Hospital Balt	DEATH	BC. COUNTY OF BEATH						
5	10s. STATE A 10b. COUNTY (10c. CITY, TOWN OR LOCATION		10d, INSIDE CITY						
- DIRECTOR	md NIA Balto		t YES 2 NO						
FUNERAL	617 HILVIEW Rd 212	25	10g. CITIZEN OF WHAT COUNTRY?						
BY	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO 11. Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT OF HIS FORCES? 1 YES 2 NO 15. YES 2 PO Spi	PANIC ORIGIN? (Specify Yeakloan, Puerto Rican, etc.) scily:	or No — 14. RACE — American Indian, Black, White, atc. Specify: Black						
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Specify only highest grade completed) (If we kind of work done during most of working life. Do NOT use regired.)	16b, KIND OF BUS	N ~ 1						
COMPLETED	Elementary/Sagopdary (0-12) College (1-4 or 5+) Welder	ma	Dry - Dock						
BE CO	1) Former's NAME (First, Middle, Last) Jackson Sr. 18. MOTNER'S	NAME (First, Middle, Maiden	dans						
TO B	180. INFORMANT'S NAME (Type/Print). Jackson (617 Hillylew)	Rd Bali	State, Zip Code) to, md 2/225						
	20 METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	CA 80 E 20c. LO	CATION - City of Town, Stata						
	21. SIGNATURE OF FUNERAL SERVICE-LICENSEE 22. NAME AND ADDRESS OF	PACILITY	mile thouse of the						
	Mala March Harn F.	Wa bast	ave !						
	23. FART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, a shock, or heart failure. List only one cause on each line.	such as cardiac or reepi	ratory erreat, Approximate Intervel Between Onset and Death						
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Gastro Intestignal Bleen	a. Gastro Intestlenal Bleeding							
		36 hrs							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR ASA CONSEQUENCE OF):								
FIC	CAUSE (Disease or Injury that Initiated events Due TO (OR AS A CONSEQUENCE OF):		2-3 years						
ERTI	resulting in deeth) LAST d. A Icahol Abuse		Years						
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given	in Part i. 24a. WAS AN PERFOR							
EDICAL	AIDS, Aepate Encephalopathy	1 TES 2	COMPLETION OF CAUSE						
2	Pancreatinis, PNEumonia, Anemia	****	t 🗆 YES 2 NO						
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERT. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	AIN (X)							
22	EXAMINER? t VES 2 NO 1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5 Residen	nea # Other (Specify)							
PHYSICIAN:	27. MANNER OF DEATN 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT	26d. DESCRIBE HOW I	NJURY OCCUREO						
ВУ Р	1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Invastigation								
- 1	3 Suicide 6 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26t. LOCATION (Street and City or Town, State)	and Number or Rural Route Number,						
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and placa, and one of the control of th								
00	2 MEDICAL EXAMINES: On the basis of axemination and/or investigation, in my opinion, death occurred at								
BE	29th SIGNATURE AND TIPLE OF CERTIFIER 29c. LICENSE 272 and 1		29d. DATE SIGNED (Month, Day, Year)						
10	30, NAME AND APORESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)		10/12/99						
	Angela Brown 225. Greene street Ballin	noe MD.	21201						
	31. DATE FILED (Month, Day, Year) OCT 1 6 1995								

1. DECEDENT'S NAME (First, Middle, Last)

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YEAR

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

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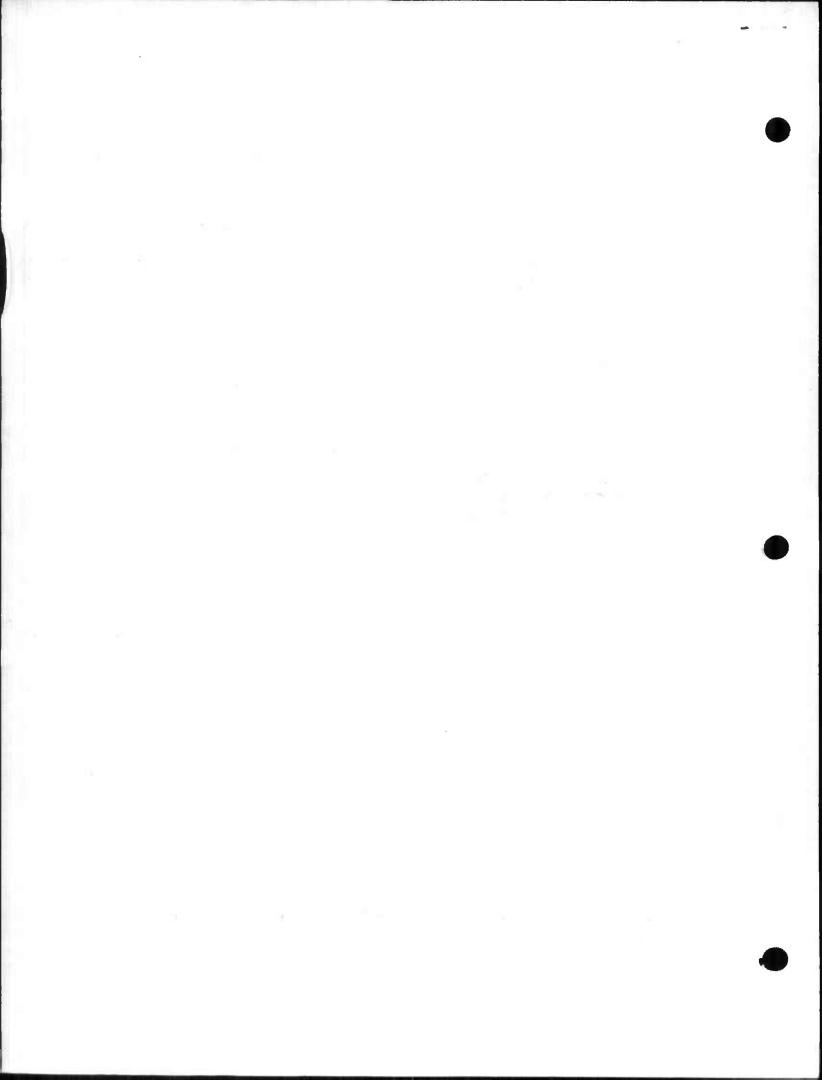
PAUL Gorman Jr. 1995 JUBB OCT 7:04 P. 7. DATE OF BIRTH (Month, Day, Year) March 2, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 220-22-4154 1 X M 2 F 66 Maryland 1929 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR City N/A 3105 MORAVIA RD. BALTIMORE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY N/A Maryland Baltimore City 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States 3105 Moravia Road 21214 funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES KOPEAN 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 X Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TYES 2 X NO Specify: BY 3 Widowed 4 Divorced White ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Stevedore Railroad once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Paul G. Jubb Sr. to Elizabeth Phillips notified ; 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 Linda F. Jubb 1366 Limit Ave. Baltimore, Md. must be 20a. METNOD OF DISPOSITION
1 X Burlai 2 Cremation 3 Framoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Parkwood Cemetery 10/17/95 Baltimore Maryland Donation 8 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Milton J/ Knight Jr Leonard J. Ruck, Inc. 5305 HarfordRoad Baltimore, Md. 21214 filled in by the figure, or removal. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical 23. PART I. Enter the disease, or complication shock, or heart fallure. List on Approximate IMMEDIATE CAUSE (Final Onset and Death the cremation. disease pr condition resulting in deeth) ATHOROSUCTION CAMIONAS CUIAN DISOSF and completely other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burfal. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate ceuse. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 0 the atten Mental F Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE any 1 YES 2 400 OF DEATH? 23 shows 1 YES 2 NO t, of h INPERM DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: Dept. certificate has 28. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem State EXAMINER? OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA r this certific 4 ☐ Nursing Home 5X Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO ΒY TO THE FUNERAL DIRECTOR: After to be filed within 72 hours after death v IMPORTANT; If Item 28 is mart 2 Accident 28a, PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER

(Check only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 👽 MEDICAL EXAMINER: On the bests of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. MURE AND TISLE OF CE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 분 분 를 ite O.C.M.E. ▶OCT. 13, 1995 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 32. REGISTRAR'S SIGNATURE 6 1995 **DHMH-16 Rev 1/89**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

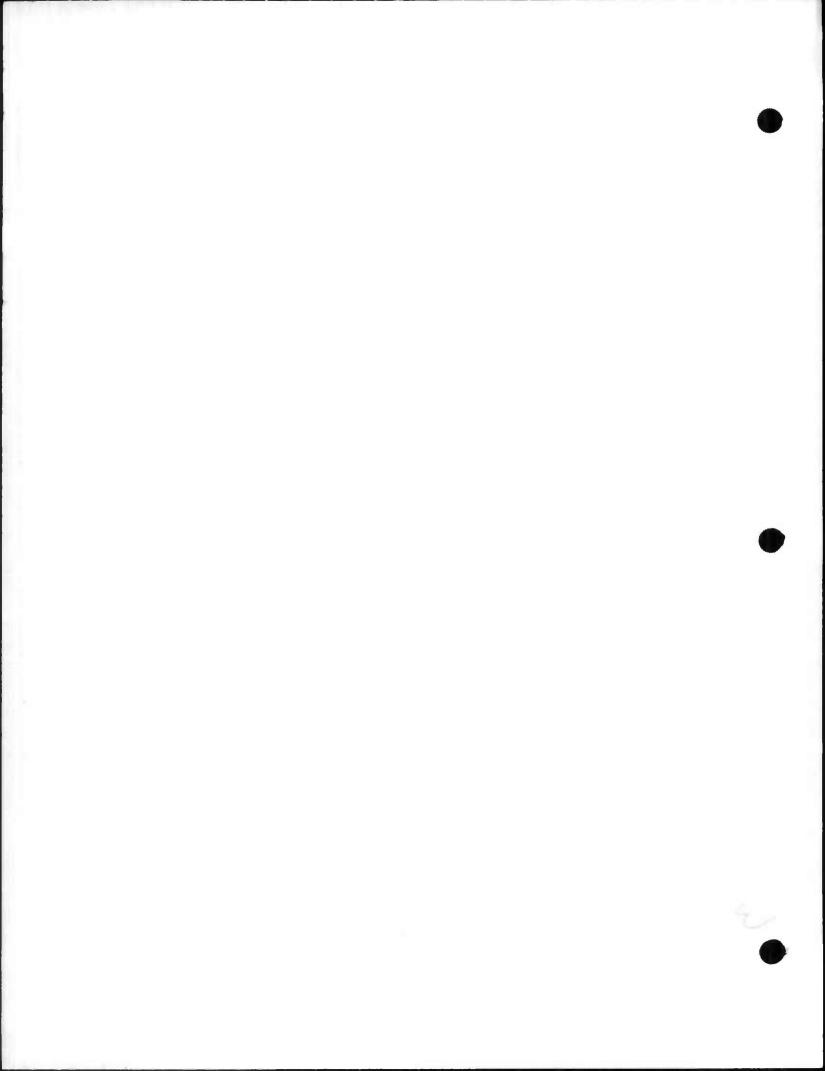


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	nsit permit. Pages 1, 2, 3 should		
HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-transit permit. Panes 1, 2, should		at once.
fter death. Page 6 may be retained	the funeral director, page 5 should	oval.	ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ate be executed within 24 hours at	ysician and completely filled in by	th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	r traumatic event, the medic
w requires that the death certific	been signed by the attending pl	pt. of Health and Mental Hygiene	3 shows any Injury, or othe
ATTENDING PHYSICIAN: The Ia	CTOR: After this certificate has	after death with the State De	ANT: If item 28 is marked, or item 2:
HOSPITAL OR /	FUNERAL DIRE	within 72 hours after death	TANT: If item

	1 - FOR STATE REGISTRAR	TE OF MARYLANI	D / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIENS				
	1. DECEDENT'S NAME (First, Middle, Last)	(JONES)				2. DATE OF DEATH DAY	1 1995	3. TIME OF DEATH 2:35 PM		
		# 2½F 69	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) O1-15-26							
TOR	9a. FACILITY NAME (If not institution, give arrest and LIBERTY MEDICAL RESIDENCE OF DECEMENT				ORE, MA		N/A	EATH		
DIRECTOR	MD . N/A			TIMORE	ION		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 4017 LIBERTY HEI	GHTS AVE	NUE		ZIP CODE 21207		10g. CITIZEN OF V			
ВУ	1 Never Married 2 V Married FO	S DECEDENT EVER IN U.S RCES? 1 YES 2 YES, GIVE WAR OR DATES	XNO	If yes, spi	ENDENT OF HISPAN city Cuben, Mexica 2 X NO Specify	IIC ORIGIN? (Specify Yes on, Puerto Rican, etc.)	or No- 14. RAC	E — American Indian, k, White, etc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (6-12) Colleg	od) pe (1-4 or 5+)	Give kind of we life. Do NOT use		N at of working	16b. KIND OF BUSI				
BE COM	17. FATHER'S NAME (First, Middle, Last) OTIS FLEMING				CARRIE	ME (First, Middle, Malden S MCCURR	urname) Y			
5	BETTY WILLIAMS					Coute Number, City or Town,		21009		
	20b. PLACE AND DATE of Disposition (Name of Date States Donation 5 of Other (Specify) 20b. PLACE AND DATE of Disposition (Name of Cornellory, cremetory,									
	21. SIGNATURE OF FUNERAL SERVICE LIGENSEE	In a	_		ERT P.	WYLIE F,	/H PA ET 212	17		
CERTIFICATION	23: PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, interval Between Onset and Death ID days Approximate interval Between Onset and Death ID days Due To (or as a consequence of): Approximate interval Between Onset and Death ID days Due To (or as a consequence of):									
PHYSICIAN: MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Careformetor 24a. WAS AN AUTOPPY PERFORMED 24b. WER ANAUTOPPY PERFORMED 1 YES 2 INO OF E 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 DID									
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 In Ing	26. P PITAL: patient 2 ER/Outpatient		OTHER:	5 Residence	8 ☐ Other (Specify)				
ВУ РНУ	1 Natural 5 Pending 2 Accident Investigation	a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJU RY WOR M 1 V	RY AT	28d. DEŞCRIBE HOW IN.	JURY OCCURED			
	3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, atreet, factory, office City or Town, State) 28e. PLACE OF INJURY — At home, term, atreet, factory, office City or Town, State)									
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To one) 2 MEDICAL EXAMINER: On the) and manner as stated.		
TO BE	206, SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEATH	UTEM 27) (Type, F	Print)	D413	65	Date SIGNED	(Month, Day, Year) EV 11, 1995		
	George E. Wick	REGISTRARIS SIGNATUR) IE O	2600	Liberty	Heights	Ave	21216		
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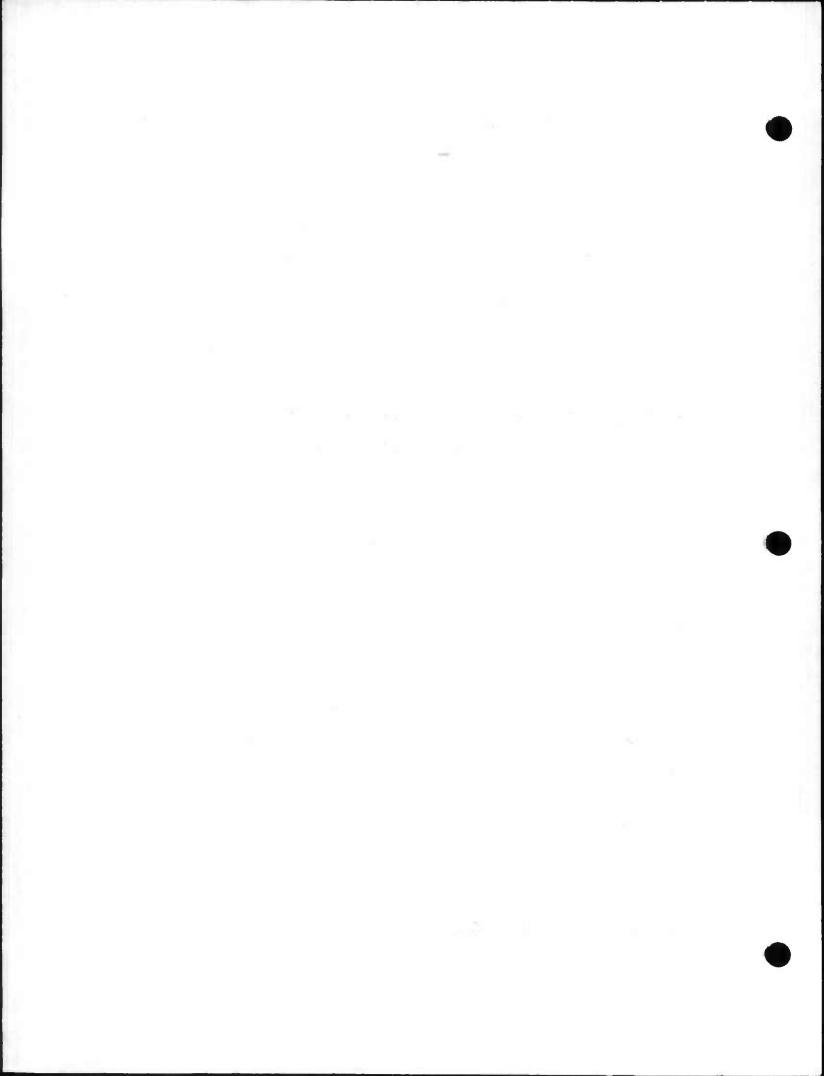
TO THE HOSPITAL D
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Be filed within 72 h
IMPORTANT: It is

marked,

Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH DCI THE Robert James Kettle, Jr. 12 9:21 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign JUNE 16,1957 216-72-8944 DAYS HOURS 1 XM 2 F 37 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Joseph Richey Hospice N/A Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 315 East University Parkway 21218 USA 11. MARITAL STATUS
1 ANover Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whita, atc. 1 YES 2 NO Specify Specify: White BY 3 Widowed 4 Divorced 1977 - 1979 COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Computer Analyst Insurance Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert James Kettle, Sr. Mary Angela Ewers BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, Shannon Patrick Riggs 315 East University Parkway, Balto., MD 21218 20a. METHOD OF DISPOSITION
1 Burlel 2 A Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Metro Crematory, Inc. 10/14/95 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES Cremation Society of Maryland, Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximats IMMEDIATE CAUSE (Final Onset and Death Respiratory arrest
Preumocystis preumonia disesse or condition reaulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 (Vother (Specify) Hospice 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide determined 29s. CERTIFIER
(Chack and) [CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D32600 10/13/95 2 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia A. Haller, MD 600 N. Wolfe St. Baltimore, MD PRECISTRAP SIGNATURE





TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retain	Sho	
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Ψ	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	,	1. DECEDENT'S NAME (First, FLOYD		OCKLEY							2. DATE (OBER 3	Y ₀ 1	955	3. TIME OF DEATH 13:53 D
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.				MONTHS DAVE MOURS MIN			R 24 HRS.	7 DATE OF BIRTH			PLACE (State or Foreign		
3 should	œ	223-26-8783 1 KM 2 F 82 VRS. MONTHS DAYS HOURS MIN. AUG. 31,1913 VIRGINIA 90. FACILITY NAME (If not institution, give street and number) 514 OAKLAND AVENUE 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 1/a										EATH			
ci	CTOR	RESIDENCE OF DECEDENT													
nit. Pages	DIREC	MARYLAND	teb. COUNT	n/a		10c. CI	Y, TOWN	BAI	LTIM						10d, INSIDE CITY XX LIMITS? 1 YES 2 NO
ansit per	FUNERAL	100. STREET AND NUMBER	OAKLAI	ND AVENU	JE			10	. ZIP COE	212	12			TED	STATES
as the burial-transit permit. Pages 1,	BY	11. MARITAL STATUS t Never Merried 2 X X 3 Wildowed 4 Divo		12. WAS DECEDED FORCES? IF YES, GIVE	NT EVER IN U.S. A	RMED NO	13.	If yes, sp		an, Mexica	an, Puerto R	(Specify Yes can, etc.)	or No—	Black	- American Indian, k, White, etc.
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be detach	E COMPL	17. FATHER'S NAME (First, Micros, Laut) CECIL LOCLEY 18. MOTHER'S NAME (First, Micros, Melden Surneme) BESSIE BROKENBERRY										2.1021			
e 5 should notified	TO B	MARY H	LOCK	KLEY	1	9b. MAILING 514	ADDRES	OAKI	AND	or or Rural AVI	Route Numb ENUE,	BALT	, NORE	Code)	21212
rector, page must be		20b. PLACE AND DATE OF DISSONTION DATE 20c. LOCATION — City or Town, State COMPLETE OF DISSONTION OF DISSONTION (Name of Complete													
al. examiner		21. SIGNATURE OF FUNERAL SERVICE LIGHTS SERVICE LIGHTS WM. C. MARCH FH1101 E. NORTH AE.													
completely filled in by the cremation, or remova event, the medical		23. PART Lenter the dehock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fellure.	a. Due To	BP O (OR AS A CONSI	····		r the mo	ode of dy	/Ing, suc	ch as cerd	ac or respi	ratory an	rest,	Approximata Interval Betwe Onset and Dec
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached Heath and Mental Hygiene prior to burial, cremation, or removal. Wes any injury, or other traumatic event, the medical examiner must be notified at once.	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. SIP CVA DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d. CAPEMIC													
n signed by the att Health and Menta Ows any injury,	MEDICAL C	PERFORMED? 1 YES 2 NO ON									WERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t yes 2 No				
Dept. of 23 she	_	DID TOBACCO U		RIBUTE TO CA		ATH Y				CERTAI	N 🗆				
rtificate h he State f or item	SICIAN:	EXAMINER?	O WEDICAL	HOSPITAL:	☐ ER/Oulpetient		OTHE	R:		Residence	6 🗆 Other	(Specify)			
fter this cer sath with th marked, o	ву РНУ		Pending Investigation	28e. DATE O (Month,	F INJURY Day, Year)	28b. TII	ME OF JURY M	W	JURY AT ORK? YES 2	_ NO	28d. DES	CRIBE HOW I	NJURY OC	CURED	
ECTOR: An s after dea n 28 is n	ETED 8	3 Suicide 8 4 Homicide	Could not be determined	28e. PLACE building	OF INJURY — At I I, etc. (Specify)	nome, ferm,	atreet, to	ctory, offic				TION (Street or Town, State)		r of Rural :	Route Number,
THE FUNERAL DIRECTOR: After this certificate has been filed within 72 hours after death with the State Dept. of IPORTANT: If Item 28 is marked, or Item 23 sho	COMPLE	onel		ICIAN: To the best of											s) end manner es stated
TO THE FUNERA DE filed within 7 IMPORTANT:	TO BE (29b. SIGNATURE AND TITLE	ma	u ur	m				29c. LIG	DOE	MBER 3093	3	29d. DAT	E SIGNED	(Month, Day, Year)
LI		30, NAME AND ADDRESS O	o R	rehms h	ore,	Λ	e, Print)	m		161	3				
1		OCT 1 6 19	95	32. REGISTE	AR'S SIGNATURE										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

95

1. DECEDENT'S NAME (First, Middle, Last)

3. TIME OF DEATH

REG. NO.

DAY

2. DATE OF DEATH

OCT.12,1995 14:58 P M KENNETH STEVEN LEMBACH 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. Feb. 13, 1967 DAYS HOURS 1 M 2 - F 28 YRS 218-02-0590 Maryland permit, Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR KIMBROUGH ARMY HOSPITAL Ft. Meade ANNE ARUNDEL toe. STATE tob. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Odenton EX YES 2 NO Maryland Anne Arundel 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 489 Monterey Ave. 21113 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Wildowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 11 Truck Driver Transportation once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumeme; to Milton W. Lembach Martha Lucille Hizer notified ton, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 General Delivery, Quinwood, WV 25981 Martha L. Lembach pe 20s. METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State
4 Donation 5 The (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must t Wallace Memorial Cemetery 10/16 Clintonville, WV examiner 21. SIONATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. Year 6009 Harford Rd., Baltimore, MD filled in by the medical 23. PART L Enter the diseases, or complications that couped the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one ceuse on each line. Approximate Interval Between 0 IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ HANGING and completely fi burial, cremation resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician ar Mental Hygiene prior to I If any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted evente reauiting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Health and PERFORMED? WAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DIRECTOR: After this certificate has been s hours after death with the State Dept. of H Item 28 is marked, or Item 23 show DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO VIOLENTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8X Other (Specify) IN VAN 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending investigation Sursieur Halled Sere MITEM 1 YES 2 NO FOUND 10 12 91 BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 8 Could not be COMPLETED 4 Homicide determined MAN 484 MONTEREY AUG AMPEDEUNDER W 29e. CERTIFIER (Check only one)
290 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and manner se stated. FUNERAL WITHIN 72 h IMPORTANT: II 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE THE rolle OCME OCT.13,1995 223 2 NAME AND AD PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDONOD A. KORSU 111 Penn Street, Baltimore, Maryland 21201 32 REGISTRAR'S GNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

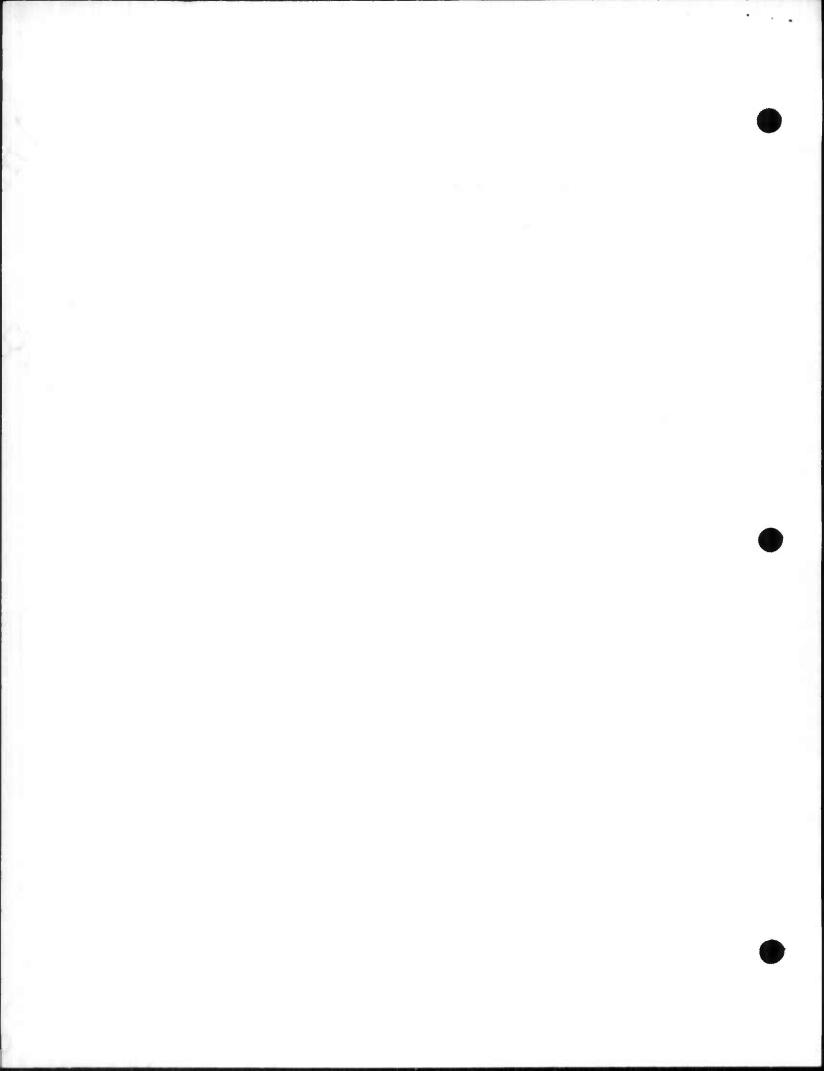
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REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AYNC October 13 1995 Ellen 11:30 A 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. s. BIRTHPLACE (State or Foreign Feb. 13 1 - M 2 - F HOURS Maryland 212-36-4851 56 1939 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Baltimore Meridian Muli-Medical N. H. Towson DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION
Monkton 10d. INSIDE CITY Md. Baltimore 1 YES 2 KNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15004 LaVale Rd. 21111 death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician afterding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit intal Hygiene prior to burial, cremation, or removal. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No--if yes, specify Cuben, Maxicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 1 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Second 12 College (1-4 or 5+) Book Keeper Jacksonville Pharmacy once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Frank Benskie notified at Helen Swiston BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 William Layne 15004 LaVale Rd. Monkton Md. 21111 9 20e. METHOD OF DISPOSITION

1 🖾 Buriel 2 🗆 Cremation 3 🗀 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE 20c, LOCATION - City or Town, State St. Johns Long Green Cem 10-16-95 4 Donation 5 Other (Specify) Hydes, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
RUCK TOWSON FH 1050 York Rd. Towson Md. 21204 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition MMUHOSUPTRESSION event. resulting in death) YEAR DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): RENAL other that initiated events resulting in death) LAST 0 this certificate has been signed by the atterner with the State Dept. of Health and Mental Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? requires that any DIABETES MELLITUS 1 YES 2 NO Shows OSTEOPOROSIS 1 TES ZV NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: MA 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Nem EXAMINER? HOSPITAL: OTHER: PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural
Accident
Suicide DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO BY ATTENDING 28e. PLACE OF INJURY -- At home, farm, street, fectory, office 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide O THE HOSPING.
TO THE FUNERAL DIRECTOR
De filed within 72 hour 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGN TURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. BE 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) (400 MZ) (OHE) 67 PARK 31. DATE FILED (Month, Day, Year)
OCT 1 6 1995 32 REGISTRAR'S OF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	424										2		1002
	1 - STATE REGISTRAR	STATE OF A	/ MARYLAND Ce		TMENT					YGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Les DEVON L.	LANCASI	'ER						2. DATE OF MONTH OCT	DEATH	1.199	YEAR	3. TIME OF DEATH 11:55 A M
	4. SOCIAL SECURITY NUMBER 216-84-6127	5. SEX	6. AGE (In yrs. les 28	t birthday) :	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF	BIRTH		. BIRTHE	PLACE (State or Foreign
OR	99. FACILITY NAME (If not institution, give 2027 CRESTVIE)	and the same of					I MOR				9c. COUNT	Y OF DE	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	ITY		10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
	Maryland	N/A				11t	imor		ity				YES 2 NO
FUNERAL	2027 Crestvie	ew Road				101	ZIP CODE	123	9		10g. CITIZE	US	HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 T	IMED NO	11	l yes, sp			NC ORIGIN? (5 n, Puerto Rica /		or No — 1	Black,	- American Indian, White, etc.
TED	15. DECEDENT'S EE (Specify only highest gra	de completed)	(G	ive kind of v	USUAL OC	CUPATIO	ON est of working	g	16b. KI	ND OF BUS	SINESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5	•)	te. Do NOT use retired.) Cook						Uni	ivers	ity	
	17. FATHER'S NAME (First, Middle, Last) Mahlon Lancas	ster							ME (First, Mick				
TO BE	19a. INFORMANT'S NAME (Type/Print)									City or Town, State, Zip Code)			
-	Rosaria Lanca	ster				_		t B	altim	_			
	1 Donation 5 Other (Specify)		20b. PLACE		d'"Na	t'	L Me		and the same of th		25 La		el, Md.
	21. SIGNATURE OF UNERAL SERVICE	B. Cs	el				O ADORE		Ca				Service 21215
LION	23. Plant is the disease of complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, above, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
PHYSICIAN: MEDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the unconditions. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES							PERFORMED? 1 YES 2 □ NO					WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 \(\text{NO} \) NO
AN	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA			TH (Check o] UNC	ERTAIL	и Ц				
SIC	EXAMINER? XXYES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 - Nurs	t: ing Horr	ne 5 X Re	sidence	8 Other (S	(pecify)			
PH	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF (Month, E			JURY		PRK?		28d. DESCR	IBE HOW II	NJURY OCCU	IRED	0
BY	2 Accident investigation	28e PLACE C	F INJURY - ALL		Sim I	1 D		NO	SUBJE 1	of STR	HNGL	1/	* STABBED
ETED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm streat, factory, office building, atc. (Specify Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number or Rural Route Number: All Location (Street and Number) (Street and Number or Rural Route Number: All Location (Street and Number) (Street and Number or Rural Route Number) (Street and Number)									BOUTIMORE			
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHY 2X MEDICAL EXAMI												end menner ee stated.
BE	As SIGNATURE AND TITLE OF CENTER	en Olle	AJ					C . M				SIGNED CT.	(Month, Dey, Year) 12,1995
6	MARIO F GOL	WHO COMPLETED CAU				ree				M	arvla	5ng	21201
	31. DATE FILED OC 1 16 190	32. REGISTR	R'S SIGNATURE		/./		-, L			- ,	ar I re	-114	27201
1	10.10.19	13 John d	him	ald.									

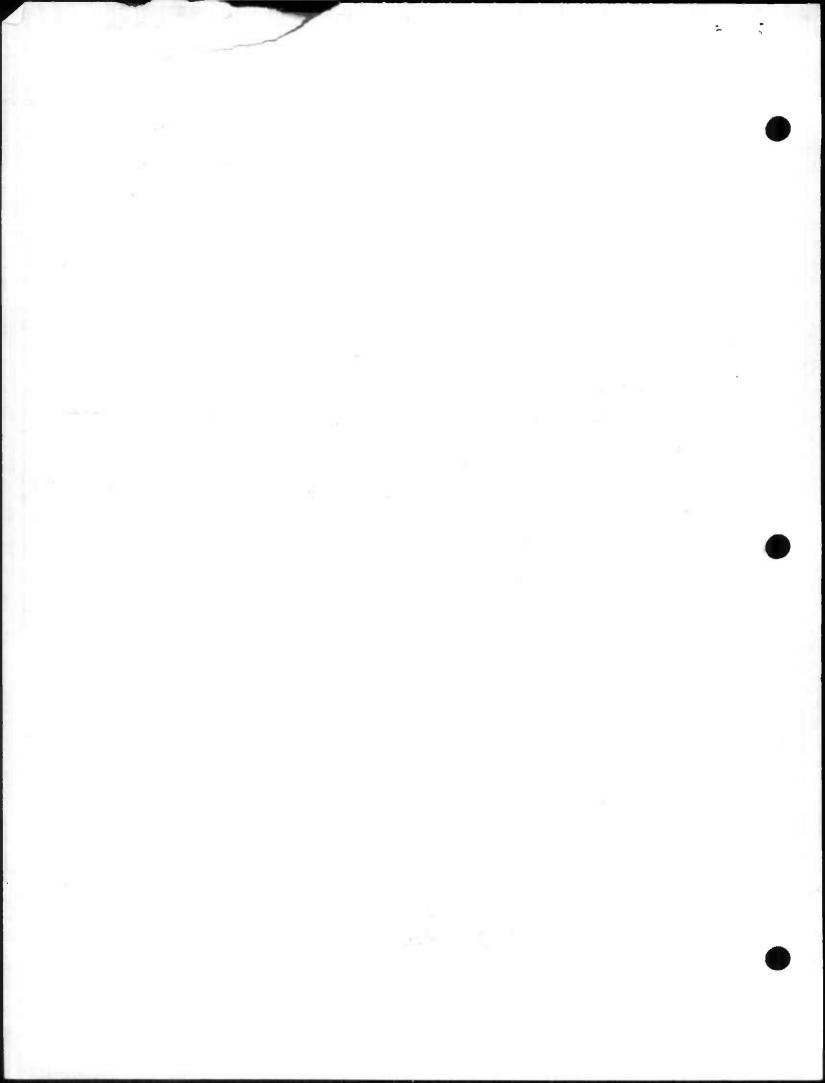
cian.	Il-transit permit. Pages 1, 2, 3 should		
AN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	are has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s	he State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.	RPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certifical	be filed within 72 hours after death with the Sta	IMPORTANT: If item 28 is marked, or its

*

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

95 31053

	FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTI			MENTAL	HYGIEN REG. NO	_	31053			
	1. DECEDENT'S NAME (First, Middle, Last) CLAUDETTE	LEIGH MC C	OLL			MONTH	OF DEATH		3. TIME OF DEATH 12:45 PM			
	4. SOCIAL SECURITY NUMBER 220-64-5853	1 □ M 2 💢 🖟	1 □ M 2 □ F 39 YRS. MONTHS DAYS HOURS MIN.					DATE OF BIRTH (Month, Day Year) 1956 BALTIMORE, MD				
TOR	98. FACILITY NAME (If not institution, give st JOHNS HOSPITAL RESIDENCE OF DECEDENT		9		TIMORE	CI	ΓΥ	9c. COUNTY				
DIRECTOR	MARYLAND 106. COUNTY	n/a	10c. CITY,	TOWN OR LOCAT	TIMORE				10d. INSIDE CITY LIMITS? YES 2 \(\text{NO}\) NO			
FUNERAL		OURT			21205			UNITE	OF WHAT COUNTRY? ED STATES			
BY	11. MARITAL STATUS 1 XXNever Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 Tyes IF YES, GIVE WAR OR DATE		13. WAS DECI	ENDENT OF HISPAR Helfy Cuban, Mexica 2 X XO Specifi	in, Puerto F	? (Specify Ye tican, etc.)	s or No- 14.	RACE — American Indian, Black, White, etc. Specify: BLACK			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12 th	CATION 10 completed) College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working a. Do NOT use retired.) IURSES ASSISTANT			MEREDI		RSING HOME			
BE CO		rler			18. MOTHER'S NA FLOR							
5	198. INFORMANT'S NAME (Type/Print) FLORENCE MC COLL 199b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 YOUNG COURT, BALTIMORE, MD 21205											
	20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, State 2 Cremation 3 Removal from State 2 Cremation 3 Removal from State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 20c. LOCATION — City or Town, State 2 Cremation 3 DATE 2 CREMATION 3											
	aloris Ma	Kryeg- X	Jours	WM.	C. MARC	H FH.			NORTH AVENUE			
CERTIFICATION	23. PART I. Entar the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heert feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) SERVE DUE TO (OR AS A CONSEQUENCE OF): HYPOSYCEMIA DUE TO (OR AS A CONSEQUENCE OF): LENAL FAILUME CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
	that initiated events resulting in death) LAST											
EDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part II.							PERFORMED? 1 YES 2 NO COMPLETIC OF DEATH?				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI		DEATH YES		UNCERTAI	N D			1 TES 2 NO			
YSICI	EXAMINER? 1 (Y YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpeti	ent 3 NOOA	OTHER:	e 5 🗆 Residence	8 🗆 Othe	r (Specify)					
ву РН	27. MANNEPOF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	OW YF	URY AT RK? 'ES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED						
ED	3 Suicide Suic								Rural Route Number,			
COMPLET		CIAN: To the best of my knowled R: On the basis of examination a							suse(s) and manner as stated.			
BE.	296. SIGNATURE AND TITLE OF CERTIFIEF	CV	29c, LICENSE NUM			>		GNED (Month, Day, Year) O 9 95				
0	30. NAME AND ADDRESS OF PERSON WHO		H (ITEM 27) (Type, P	Print)	JOHNS	Ho	pk1N	s Hos	SPITHL			
İ	31. DATE FILED (MOTE) - Day 1991 6 199	5 Java d'Estado	URE ROUGH					<u> </u>				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	ITEMS: 10d,19b, PER	F.H. FILM G-72	8 10/16/9	5 t.t			9) ;	11004	ŀ
	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN				
COMPLETED BY FUNERAL DIRECTOR	1. DECEDENT'S NAME (First, Middle, Leel)					2. DATE OF DEATH			3. TIME OF DEATH	1
	ROBERT R.			E	OCTOBER	10 1	1995	12:47	Ам	
	047 04 7700		yrs. last birthday) 56 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH NOV. 25, 19	T	8. BIRTH	PLACE (State or Fore	nian
	9a. FACILITY NAME (if not institution, give alreet end number) UNION MEMIORAL HOSPITAL				OR LOCATION OF DI					
	MARYLAND	n/a	10c. CIT	y, town or loca BALTI					10d. INSIDE CITY LIMITS? 1 XXES 2 N	40
	100. STREET AND NUMBER 1118 E. 36 th STREET				04. ZIP CODE 2121					
	11. MARITAL STATUS 1 Never Married 2 XXMarried 3 Widowed 4 Divorced	ECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— apecify Cuban, Mexican, Puerto Rican, etc.) ES 2 X No Specify: BLACK					١,			
	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPA (Give kind of work done during in the both of the completed)				10N 16b. KIND OF BUSINESS/INDUSTRY TRANSIT ADMINISTRATION					
	17. FATHER'S NAME (First, Missin, Last) BERK MOORE 18. MOTHER'S NAME (First, Middle, Melden Surneme) SALLIE RATTLEY									
TO BE	DOROTHY MOORE 196. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zip Code) 21239 21239 21239 21239									
ı	AX Burlas 2 Cremention 2 Removal from State 2 Company of Town, State 2 Company of Town State 2 Company									
1	22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH 1101 E. NORTH AVENUE									
PHYSICIAN: MEDICAL CERTIFICATION	Approximate interval Betwee Onset and De Ons								tween	
	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
	PERFORMED? AM CO OF								. WERE AUTOPSY FIN AVAILABLE PRIOR T COMPLETION OF CA OF DEATH?	0
AN: On	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								1 YES 2 N	0
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1									
	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 26c. IN				JURY AT	28d. DESCRIBE HOW	INJURY OC	CURED		
	1 Netural 5 Pending	YES 2 MO	stangeled , beaten							
	3 Suicide 6 Could not be determined 4 Homicide determined				281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)				11-	
COMPLETED	29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(e) end manner as stated. 20a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(e) end manner as stated.									
BE CO	29b. SIGNATURE AND TITLE OF CENTIPIER				29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Dey, Year) CTOBER 10, 199					
2	20 NAME AND ADDRESS OF BERROLL WALL	O.C.M.E.								

111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)

OCT 1 6 1995

Self-Colon Standard

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burfat, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 3. PER DR. FILM G-728 10/16/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH MONTH 1, DECEDENT'S NAME (First, Middle, Last) 4:50 Ам Susan A. Moore October 13,1 995 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 101 1 M 2 F 212-07-6607 May 24,1894 Maryland 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Avenue21229 St. Elizabeth's 3320 Benson DIRECTOR Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1X YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 3320 Benson Avenue 21229 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yee, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married Specify BY 3 X Widowed 4 Divorced white 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 6 clerk manufacture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Adam Sapp Mary Schevr BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210796 2 5990 Old Washington Boulevard Elkridge Mary Suzanne Moore 20a. METHOD OF DISPOSITION

1 XBuriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State ion 5 Other (Specify) New Cathedral Cemetery 10/16 Baltimore, Maryland 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road Mund er 21227 Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List drily one cause on each line. 23. PART i. Enter the Approximata interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition reaulting in deeth) DUE TO (DR AS A CONSEQUENCE OF) Lle CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE DF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (DR AS A CONSEQUENCE DE): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not reculting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? AMA 1 YES 2 LNO 1 TYES 2 FA-NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN nem 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpetient 3 | DOA OTHER:
4 Nursing Homa 5 - Residence 8 - Other (Specify) 1 TES 2 NO 6 27. MANNER DF DEATH 28a. DATE OF INJURY 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Matural 1 YES 2 ND BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide SI 92 6 Could not be detarmined COMPLETED 4 Homicide 29a. CERTIFIER

(Charle and) | PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE rsie D30182

3320

MD

RUSSELL

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DCTUBER 16, 1995

BENSON AVE BALTIMORE MD 214

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	State	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIENE REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATH
1	KENNETH	JEFFERSO	N	MOOR	\equiv d			95 9:12A M
	010 11 0500	The state of the s	rrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	210 11 0000	1 □XM 2 □ F 48	YRS.			NOV. 1,1		ashington D.
e	9a. FACILITY NAME (If not institution, give stre	et and number)			R LOCATION OF DE	ATH	9c. COUNTY	
DIRECTOR	9725 HALL ROAD			FREDE	RICK		FRE	DERICK
E	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
		erick		Frede	rick			1 TES 2 1 NO
₹	10e. STREET AND NUMBER			10f	ZIP CODE	,		OF WHAT COUNTRY?
FUNERAL	9725 Hall Road	12. WAS DECEDENT EVER IN U		1	2170		U.S.	
5	1 Never Married 2 Married	FORCES? 1- YES IF YES, GIVE WAR OR DATE	2 NO	If yes, spi	city Cuban, Maxican	IC ORIGIN? (Specify Yes n, Puerlo Rican, atc.)	or No — 14	. RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 X Divorced	11-7-63 to 1	1-4-66	1 L YES	2 NO Specify.			Specify: White
COMPLETED	15. OECEDENT'S EDUCA (Specify only highest grade of	TION 1	Ba. DECEDENT'S	JSUAL OCCUPATIO		16b. KIND OF BUS	INESS/INDUS	TRY
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	itte. Do NOT use BOOK B:	retired.)		Balmar	Prin	ting/Graphic
P P	12th grade	N.A.	DOOK D.	Inoci				orng, orapiire
	Fred Avery	Moore			Rebecc	ME (First, Middle, Meiden s A Mago		
BE	19a. INFORMANT'S NAME (Type/Print)	HOOLE	19b. MAILING	ADDRESS (Street a		loute Number, City or Town		ode)
유	Daniel B. Moor	e				derick, N		
	20a. METHOD OF DISPOSITION 1 TBuriel 2 Cremation 3 Remov		LACE AND DATE O	FDISPOSITION (Na				y or Town, State
	4 Donation 5 Other (Specify)	Am	ery, crematory o r oti erican	Legio	ı Cem	10-18Big	Ston	e Gap Va.
	21. SIGNATURE OF THEBAL SERVICE LICE	NSEE /			D ADDRESS OF FAC	CILITY		neral Home
	· prany	Janne	no	263	Conk	ling ST.	Balt	o. Md.21224
	23. PART Lighter the diseases or as ahock, or heart failure	int phy one cause on esc	he desih. Do n	ot enter the mo	ds of dying, such	ss cardiac or respir	ratory arres	t, Approximate
	IMMEDIATE CAUSE (Final disease pr condition	/		/	1 1-		-/-	Opent and Death
	resulting in desth)	OUE TO (OR AS A C	ceron	12 4	arallol	ruscular	ais	ease
		OUE TO (OH AS A C	UNSEQUENCE OF):				
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF):				
S	cause. Enter UNDERLYING CAUSE (Disease or injury							
빌	that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):				
CERTIFICATION	d.			- du				
4	PART ii. Other significant conditions	contributing to death but	not reaulting i	n the underlyin	g cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
20						1 YES 2		COMPLETION OF CAUSE OF DEATH?
MEDIC						`		1 Seves 2 No
PHYSICIAN:	DID TOBACCO USE CONTR		DEATH YE		UNCERTAIN	1 🗆		
S		HOSPITAL:		OTHER:	3737	o		
HYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Output	lent 3 L DOA		XXResidence URY AT	6 ☐ Other (Specify) 26d. DESCRIBE HOW II	NJURY OCCU	RED
	t Natural 5 Pending	(Month, Day, Year)	INJ		RK? YES 2 NO			
D BY	3 Suicide 8 Could not be	28a. PLACE OF INJURY - building, atc. (Specify	- Al home, lerm, s	traet, lactory, offic	•	261. LOCATION (Street a City or Town, State)		Rural Route Number,
ETED	4 Homicide determined		, 			Oily Or TOWN, Olally		
PLE		IAN: To the best of my knowled	ige, death occurre	d at the time, date	and place, and due	to the cause(s) and men	ner as atated	
COMPL	one) 2 MEDICAL EXAMINER	: On the basis of exemination	ind/or investigatio	n, in my opinion, c	eath occured at the	time, data and place, an	d due to the	cause(s) and manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	1111			29c. LICENSE NUM			BIGNED (Month, Day, Year)
TO B		6 06			O.C.M	i.E. OC	TOBER	15, 1995
	30. NAME AND ADDRESS OF PERSON WHO	1 1/2 -			-L D-3	4. day a	Mar 7	
	31. DATE FILED (Month, Day, Year)	, 32. REGISTRAR'S SIGNAT		n Stre	er, Bal	timore,	mary.	and 21201
	OCT 1 6 1995 A	le Studentantes						
	- 0							

TO BE COMPLETED BY FUNERAL DIRECTOR

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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

												9	5	3	00	1
	1 - FOR STATE REGISTRAR		STATE OF I	MARYL				NT OF H			MENTAL HYG					
1	1. DECEDENT'S NAME (First,	Middle, Last)									2. DATE OF DEAT	Ή			3. TIME OF I	EATH
ı	YOLANDA	There	sa	M	ATASS	5A					MONTH OCT	12	199	YEAR 95	7:1) PM
ı	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE	(In yrs. les	birthday)	IF UN	DER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		T	S. BIRTH	PLACE (State	
	203-03-1606		1 🗆 M 2 💢 F		78	YRS.	MONTH	S DAYS	HOURS	MIN.	0ct. 25			Countr	ondale	
١	9a. FACILITY NAME (If not ins		reet and number)				9b. C	ITY, TOWN	R LOCATI	ON OF DE			COUNT			11 4.
	Stella Maris	-						Tow	son				В	alt	imore	Co.
ı	10a. STATE	10b. COUNTY	,			10- 017	W TOWN	N OR LOCAT		_						
,	Maryland		altimore	Co.		10c. C11	T, IUW	Car							10d. INSIDE	
	10e. STREET AND NUMBER		220211101 0						ZIP COD			10.	- CITIZE	EN OF W	WHAT COUNTR	-71
	2815 Second	Ave.							2123			"		J.S.		**
1	11. MARITAL STATUS		12. WAS DECEDEN				T	13. WAS DEC	ENOENT C	F HISPAN	IIC ORIGIN? (Specif	y Yes or N		4 BACE	- American	Indien.
ı	1 Never Married 2		FORCES? 1 IF YES, GIVE V			0		If yes, sp	2 XNO	n, Maxica	n, Puarto Rican, etc	-)		Black	white, atc.	
	3 Wildowed 4 Divor	rced	500000000						- CAMO	Opoony				ариск	A MILL CO	3
ı	15. DECE (Specify only	EDENT'S EDUC highest grade	CATION completed)		(GF	ve kind of t	work do	OCCUPATION TO	IN st of workin	10	16b. KIND OF	BUSINES	SS/INDU	STRY		
	Elementary/Secondary (0-	-12)	College (1-4 or 5	-)	14.00	Do NOT us		,		•						
Ì	12					Secre	etar	^у				0f	fice	5		
ı	17. FATHER'S NAME (First, Mid								18, MOTI	IER'S NA	ME (First, Middle, Me	iden Sumi	ame)			
	Eraclio Jos	eph Ve	ettor						Sar	ah F	Regina B	rune	llo			
ı	19a. INFORMANT'S NAME (Ty	rpe/Print)			19b	. MAILING	ADDR	ESS (Street a	nd Number	or Rural F	Route Number, City of	Town, Ste	ste, Zip C	Code)		
	Mr. Paul S.		sa		11	Eas	st I	ladis	on St	reet	t Baltin	nore	, Ma	aryl	and 21	202
ı	26a. METHOD OF DISPOSITION 1 X Burlat 2 ☐ Crematton		oval from State	20t	PLACEA	ND DATE	OF OISE	OSITION (Na	me of		DATE 204	LOCATIO	ON — CI	ity or To	wn, Slate	
i	4 Donation 5 Dother	(Specify)		- MC	ost F	loly	Rec	<u>leemer</u>	· Cen	1. (Oct.16 9	5 B	alti	imor	e, Mary	land
ı	21. SIGNATURE OF FUNERAL	BERVICE LIC	Jeffr	ey l	Gá	ıir	1 2	22. NAME AN	D ADDRES	SS OF FAI	CILITY					
J	* Jeffe	37	- yar	_			- [5	5305 I	larfo	ord F	ck,Inc. Road Balt	timo	re.	Mar	vland	21214
1	23. PART C. Enfer the di- shock, or he	senses, or c	ompiloations tha	t cause	d the de	ith. Do r	not an	ter tha mo	de of dyl	ng, aucl	h as cerdiac or r	espirato	ry arrea	at,	Approx	
Ï	IMMEDIATE CAUSE (Fine	al	List Only One Cau	se on e	ech line.											I Batween and Death
ı	disease or condition		META	CTIAN	PTC C	יו אורים	מי									
ĺ	resulting in death)	,			CONSEC											
			CONG	EST1	VE H	EART	FZ	TURE	7						j	
	Sequentially list condition if any, leading to immed	liete)		CONSEQ			- 2010							-	
	cause. Enter UNDERLYIF CAUSE (Disease or injur															
	that initiated events resulting in death) LAST	·	DUE TO	(OR AS A	CONSEQ	UENCE O	F):									

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMEO? 1 TES 2 NO

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1	YES	2	NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 1 YES 2 100 26. PLACE OF DEATH (Check only one) 27. MANNER C HOW INJURY OCCURED

1 2 3010	1 LJ Imperient 2 LJ Er/Quipetient	3 LI DOA	Nu Chu	rsing Home 5 🗌 Residence	6 Other (Speci
OF DEATH	(Month, Day Year)	28b. TIME INJU		25c. BUJURY AT WORKY	28d. DESCRIBE

Accident	5 Pending Investigation	M 1 VES 2 NO	
Suicide	6 Could not be	alse. PLACE OF INJUSTY — At home, farm, street, factory, office building, stc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

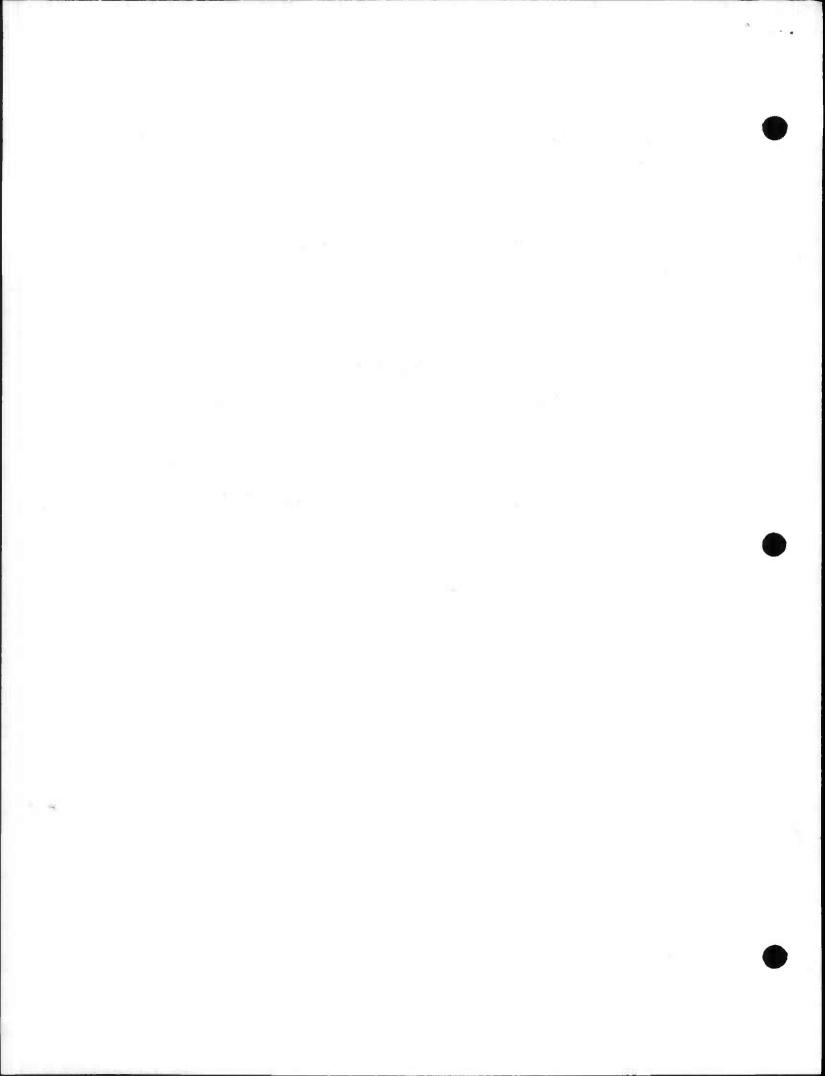
PERSONAL PROPERTY AND PERSONS NAMED IN		_	
29s, CERTIFIER (Chace cody	CERTIFYING PHYSICIAN	Sq In	best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
Out)	2 MEDICAL EXAMINER: O	n tring to	esis of magnington and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as star

The state of the s	non, in my opinion, death occured at the time, date and pl	ace, and due to the cause(a) and manner as sta
29b. SIGNATURE AND TITLE OF CERTIFIER	29 OCENSE NUMBER /	29d. DATE SIGNED (Month, Day, Year)
	1/15507	10 13 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2300 DULANEY VALLEY RD EDDIE NAKHUDA, M.D. TOWSON, MD 21204

AL PRESENTENCE OF THE PARTY OF



Pages 1, 2, 3 should

. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit he filed within 72 hours after clearly with the State Deut of Health and Mental Hysiere prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death cer	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 he fled within 72 hours after clearly with the State Deut of Health and Mental Hydiene prior to burial, cremation, or removal.	4T: It Item 28 is marked, or Item 23 shows any injury, or of

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF E		VEAR	3. TIME OF DEAT	Н
	EDGARDO		LUGO	PEREZ		OCTOB	ER 7, 1	1995	4:15	PM.
	4. SOCIAL SECURITY NUMBER 584-23-7990	5. SEX 6. /	GE (In yrs. lest birthday) 29 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day Oct 25	IDTM	8. BIRT Coun		reign
	9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TOWN	OR LOCATION OF O			Puer	cto Rico	_
DIRECTOR	BARRYS HILL RO			BRYANS					S COUNT	ГҮ
E	10e. STATE 10b. COUNTY			TOWN OR LOCA	TION				10d. INSIDE CITY	
ā	Texas Tra	vis	Au	ıstin					LIMITS?	NO
FUNERAL	100. STREET AND NUMBER 1332 Briarhollow	Drive		10	78729		10g.	USA	WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 12. Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 [] IF YES, GIVE WAR (YES 2 X NO	If yee, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 NO Speci	en, Puerto Rican		14. RAC Blac Spec		ın,
ED 8		147.01	Las assessment		erto Ric	-			White	
=	15. DECEDENT'S EOUC (Specify only highest grade	completed)	16a. DECEDENT'S I (Give kind of w life. Do NOT use	ork done during me		16b. KIN	O OF BUSINESS	INDUSTRY		
7	Elementary/Secondary (0-t2)	College (1-4 or 5+)		,		1	M			
COMPLET	17. FATHER'S NAME (First, Middle, Last)	4	Labor	er	18, MOTHER'S N		Museums			
2	Victor Lugo				Luz P		, Maiden Sumam	(a)		
8	19e. INFORMANT'S NAME (Type/Print)		19h. MAIL IMG	ADDRESS (Street	and Number or Rural		thy or Youn Crass	7lo Codel		
임	Felipe Lugo Perez				llow Dri				29	
	20e. METHOD OF DISPOSITION Burlel 2 Cremation 3 Remo		20b. PLACE AND DATE O	F DISPOSITION (N	nme of	DATE	20c. LOCATION	- City or T		
			Cemetery cremetory or oth			10/14_	Ponce,	PR		
	21. SIGNATURE OF FUNERAL SERVICE LC	ENSEE	_	Ster	ing Ash Ling Ash Edmondso	ton Fun			1. 21228	
CERTIFICATION	ahock, or heart fellure. In immediate cause or condition reauting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reauting in death) LAST	a. Bluf DUE TO (OR	AS A CONSEQUENCE OF):	to He	ind			Interval B Onaet and	
Ö	PART il. Other algnificent condition	a contributing to dea	th but not resulting in	n the underlyin	n cause alven ir	Port i 24e	. WAS AN AUTOP	ev 124	b. WERE AUTOPSY FI	NDINGS
MEDICAL							PERFORMED?		AVAILABLE PRIOR COMPLETION OF	TO
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUS			UNCERTA	N 🗆			-)	
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	H (Check only one) OTHER:						
PHYSICIAN:	TXXYES 2 NO	1 🗆 Inpatient 2 🗆 ER		4 Nursing Hon	e 5 🗆 Reeldence	- A A		CAR		
BY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. DATE OF INJI (Month, Day, YI Fex 10/7 28e. PLACE OF IN. building, atc.	JURY — Al home, farm, s	JRY WO		cub, e	N (Street and Nur wn, State)	-ck n	11 H Chart Route Number, Bryanst	ROA
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE	CIAN: To the best of my	knowledge, death occurre						(e) end menner se s	teted.
CC	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d.	DATE SIGNE	D (Month, Day, Year)	
0	Theodore P.	Kind	mil			.M.E.			R 8,199	5
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE O	F DEATH (ITEM 27) (Type,	Print)	0.0	· rı · Li ·	NC.	CDEI	. 0,199	
	THEONORE MIK 31. DATE FILED (MONTH, Day, Yber)	est	111 Pe		eet, B	altimo	re, M	aryla	and 212	01
	OCT 1 6 1995	Jali de	Clear Kardell							

age 1

ALTIMORE, MARYLAND 21215-0020

60 BALTIMORE, MARYLAND 21215-0020	within 7.4 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	vent, the medical examiner must be netified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at onea.

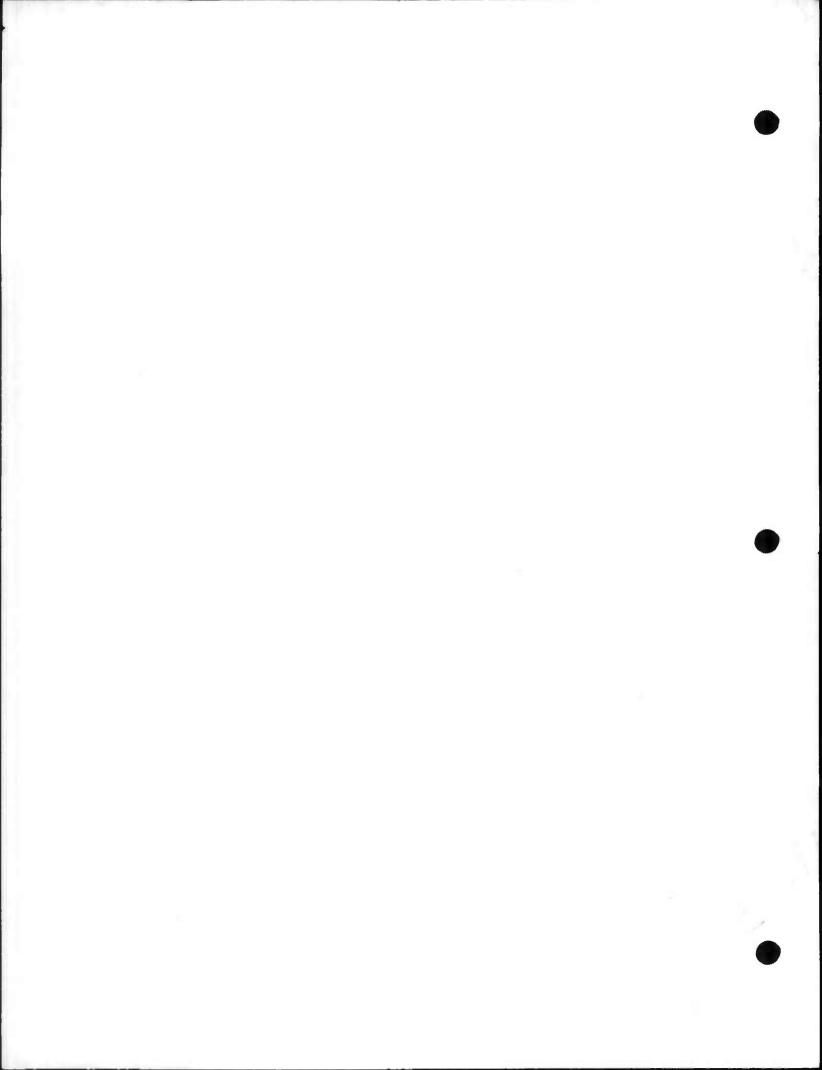
1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAL				OLINI	ILIC	AIE OF	DEA	In	REG. NO).		
	1. DECEDENT'S NAME (First	, Middle, Last)	D - 1	. 7 7						2. DATE OF DEATH	AY .	YEAR	3. TIME OF DEATH
	James S		_	alleg						October I	2, 19	95	10:54 A M
	4. SOCIAL SECURITY NUMBER	BER	5. SEX		yrs. last birthd		THE DAYS	# UNDER	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Ybar)		8. BIRTHP	PLACE (State or Foreign
	710-07-957		1 € M 2 □ F	77	YR	3.	TITLE DAYS	HOURS	Mire.	9-25-1918	3	Illi	
_	9a. FACILITY NAME (If not in	stitution, give	street and number)			9b.	CITY, TOWN	OR LOCATI	ON OF DEA			NTY OF DE	
DIRECTOR			more Medi	cal C	Center		To	wson			Ba	altimo	ore
[[RESIDENCE OF DEC	10b. COUNT	~			O/T/ T/							
<u>E</u>							OWN OR LOCA	TION					10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	Bal	timore		T	imo	nium						1 YES 2 NO
R		D.1					10	f. ZIP COD					HAT COUNTRY?
FUNERAL	2202 Foxle	y Ra.							093		U.S		
	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES	2 3 NO		13. WAS DEC	CENDENT (OF HISPANIC In, Maxican,	C ORIGIN? (Specify Ye Puerto Rican, etc.)	s or No-	14. RACE Black,	- American Indian, White, etc.
B	3 Widowed 4 Divo	-	IF YES, GIVE V	AR OR DAT	ES		1 🗌 YES	2 X NO	Specify:			Specify	
8		EDENT'S EDU			16a. DECEDEN	T'S USU	AL OCCUPATION	ON		16b. KIND OF BU	CINECC/IN	Whi	ce
	(Specify only Elementary/Secondary (0	y highest grade	College (1-4 or 5		(Give kind life, Do NO	of work	done during me	ost of working	ng	Tool Kills of So	0.112.07.111	DOSTAT	
7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7.2,	6 yrs	"	Exec	utix	<i>r</i> e			Marti	n Mai	cietta	9
COMPL	17. FATHER'S NAME (First, M	Iddle, Last)						18. MOT	HER'S NAM	E (First, Middle, Maiden			
	James Rus	sell	Penhalle	gon					ssie		rman		
BE	19a. INFORMANT'S NAME (7			J	19b. MAIL	ING ADD	DRESS (Street a			ute Number, City or Tox		n Codel	
임	Virginia D.	Penha	allegon							nium, Md.			
	20a. METHOD OF DISPOSIT			20b.P	LACE AND DA	TE OF DE	SPOSITION (N					City or Tow	n, Stata
	1 Surial 2 Crematio		oval from State	Dul	laney	Vall	Ley			10-16 Tim			
	21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE				22. NAME A	ND ADDRE					
	1/1	-11	12	/			Ruck '	Towso York	n Fu	neral Hom Towson, M	d' 21	204	
	23. PART I. Enter the di	saases, or	complications that List only one cau	t caused t	the death. D	o not a	inter tha mo	da of dy	ing, such	as cardiac or resp	iratory ar	rest,	Approximate
	IMMEDIATE CAUSE (Fin		A COMY ONE CEN	_		•		1					Interval Between Onset and Death
	disease or condition	→ /	a.	110	pera	1.1	810	سامه	a				3 week
			DUE TO	(OR AS A C	ONSEQUENCE	OF):							
Z	Sequentially list conditi		b		AA	0	S						"
CERTIFICATION	If any, leading to immed	diata	DUE TO	(OR AS A C	ONSEQUENCE	OF):	2			elmat			111
2	cause. Enter UNDERLYI CAUSE (Disease or inju		C		ONSEQUENCE	uge	ner !	9	bank	imab	72		2 mones
Ė	that initiated events resulting in death) LAS	т	DUE 10	(OR AS A C	ONSEQUENCE	OF):							
8 1			d										
	PART ii. Other aignifica	nt condition											VERE AUTOPSY FINDINGS
EDICAL	- Acute,	Kengel	fache	u,	Rule	ツツ	range	Ede	ing	PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	Ba	ctere	me	A	udo	4	0				20110	- 1	OF DEATH?
	DID TOBACCO U						J NO E	UNC	ERTAIN				
N N	25. WAS CASE REFERRED TO EXAMINER?	-			. PLACE OF D								
SIC	1 VES 2 NO		HOSPITAL:	ER/Outpati	lent 3 🗆 DO/		HER: Nursing Hom	ne 5 □ Ra	sidence 8	☐ Other (Specify)			
PHYSICIAN	27. MANNED OF DEATH		28a. DATE OF (Month, D	INJURY IV. Year		TIME OF	28c, INJ	URY AT	1	ted. DESCRIBE HOW I	NJURY OC	CURED	
ВУ		Pending Investigation	1	,,				YES 2	NO				
		Could not be	26a. PLACE Of building,	F INJURY —	- At home, fari	n, street	, factory, offic		2	281. LOCATION (Street : City or Town, State)	and Number	or Rurel Ro	ute Number,
ETE	4 Homicide	determined								ony or ionni, oteley			
2	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowled	ige, death occ	urred at	the time, data	and place,	and due to	the cause(s) and ma	nner as stat	ed.	
COMPL													and manner as stated,
<u></u>	296. SIGNATURE AND TITLE	OF CERTIFIE	A .					29c. LICE	NSE NUMB	ER	29d, DAT	E SIGNED (Month, Day, Year)
0	Grorge 1	5. Kg	mar	M	0			D	161	89	> ,	10-10	2-95
2	30. NAME AND ADDRESS OF CLEOR LE 1	PERSON WH	O COMPLETED CAUS	E OF DEATI	H (ITEM 27) (7	rpe, Print,)	~ -		c. c.1	-/-	- 0	2 ,
	WEORLE A	S.KAK				6:	5 N.	Cha	ele,	St. Sund	615	- 10u	15 Dr 6/204
	OCT 1 6 199	5 Ju	lin athurhan	Red SIGNATI	M.								
		- (/											

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ohysician.	burial-fransit permit. Paner 1.2.3 should			
incate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Panes 1 2 3 show		caminer must be notified at once.	The second secon
he law requires that the death certificate be executed within 24 hours after de-	gned by the attending physician and completely filled in by the fu	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HUSPITAL OR ATTENDING PHYSICIAN: The law require	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician	be filed within 72 hours after death with the State Dept. of Hea	IMPORTANT: If item 28 is marked, or item 23 shows	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFICA	ENT OF H	EALTH AND	MENTAL HYGIEI		
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH
\	Bobbie Jean Pel	legrini					0AV YE	11.25 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In		NOER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.8	HRTHPLACE (State or Foreign
	214-26-4555	1 □ M 2 X F 66	YRS. MON	THE DAYS	HOURS MIN.	(Month, Day, Year)		Kentucky
	9e. FACILITY NAME (If not institution, give street	at and number)	96.	CITY, TOWN C	R LOCATION OF D		9c. COUNTY	
DIRECTOR	4601 Furley Avenu	e		Baltim	ore		N/A	
Ä	10e. STATE 10b. COUNTY			WN OR LOCAT	ION			10d. INSIDE CITY VLIMITS?
	MD N/A		Baltin	nore				1 TYES 2 NO
FUNERAL	100. STREET AND NUMBER 4601 Furley Ave	enue		101	21206		U.S.	OF WHAT COUNTRY?
S		12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Ye	s or No- 14, 1	RACE — American Indian,
ВУБ	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? t YES	ESXX	If yes, spi		an, Puerto Rican, atc.)		Black, White, etc. Specify:
					^			White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	(Non impleted)	(Give kind of work of	lone during mo		16b. KIND OF BU	ISINESS/INDUSTI	RY
7		College (1-4 or 5+)	life. Do NOT use retir	ed.)		Photogr	apy Stu	idio
M	17. FATHER'S NAME (First, Middle, Last)		Clerk					10.10
	Verlin Smith					AME (First, Middle, Melde) Lockhart	Sumeme)	
B	19e, INFORMANT'S NAME (Type/Print)							
2	Donna Pellegrini		4601 Fur	ley A	venue Ba	Acute Number City or To	vn, Stete, Zip Code laryland	1 21206
	20g. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 2 Remove	20b.F	LACE AND DATE OF DIS		me of	DATE 20c. L	DCATION — City	or Town, State
- 1	4 - Donatiper-5 - Other (Spegile	Mo.	tery, cremetory or other pasts. Re	deeme	r Cemete	rv 10/18/9	5 Balto	o. MD
	21. SIGNATURE OF FUNERAL DERPICE LICEN	+(1) 11	11/1	22. NAME AN	D ADDRESS OF FA	CLUTY The Dir	pel Fur	neral Home Inc
	1 Jakon	1 Julie	1	7110	Belair R	oad Baltin	ore. Ma	ryland 21206
CERTIFICATION	23. PART I. Enter the diseases, or catock, or heart failure. If the process of condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):			lung		Approximate interval Between Onset and Desth
MEDICAL	PART II. Other significent conditions of the con	estructive	pulin	orac	y dix	PERFO 1 VES	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26	. PLACE OF DEATH (C	eck only one)	***			
ō		OSPITAL: Inpatient 2 ER/Outpat	lent 3 DOA 4 D	HER: Nursing Home	5 KResidence	8 Other (Specify)		
	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	JRY AT	28d. DESCRIBE HOW	INJURY OCCURE	D
	Natural 5 Pending 2 Accident Investigation				ES 2 NO			
3	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	At home, farm, street,	factory, office		281. LOCATION (Street City or Town, Stete	end Number or Ru	ral Route Number,
MPLE	290. CERTIFIER A NEGOTIEVING PHYSICIA	M. To the head of			W337-01-02			
E		AN: To the best of my knowled On the besis of exemination of						
3		THE STATE OF TAXABLE PORT OF	mweetigetion, in	rry opinion, de			na due to the ceu	se(s) and manner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	2.100. Nn	\sim		29c. LICENSE NUI	MBER /	. /	NED (Month, Day, Year)
2	JAMES AND ADDRESS OF THE PARTY	uccey 11			D735	41	10/1	16/95
	30 NAME AND ADDRESS OF PERSON WHO CO	MOD BELEVI	H (ITEM 27) (Type, Print)	Famil	y Hear	Hu Centa	1213	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE	Try	11/10	y www.		
	UU 1 10 1995 /w	A COMPLETE	es					

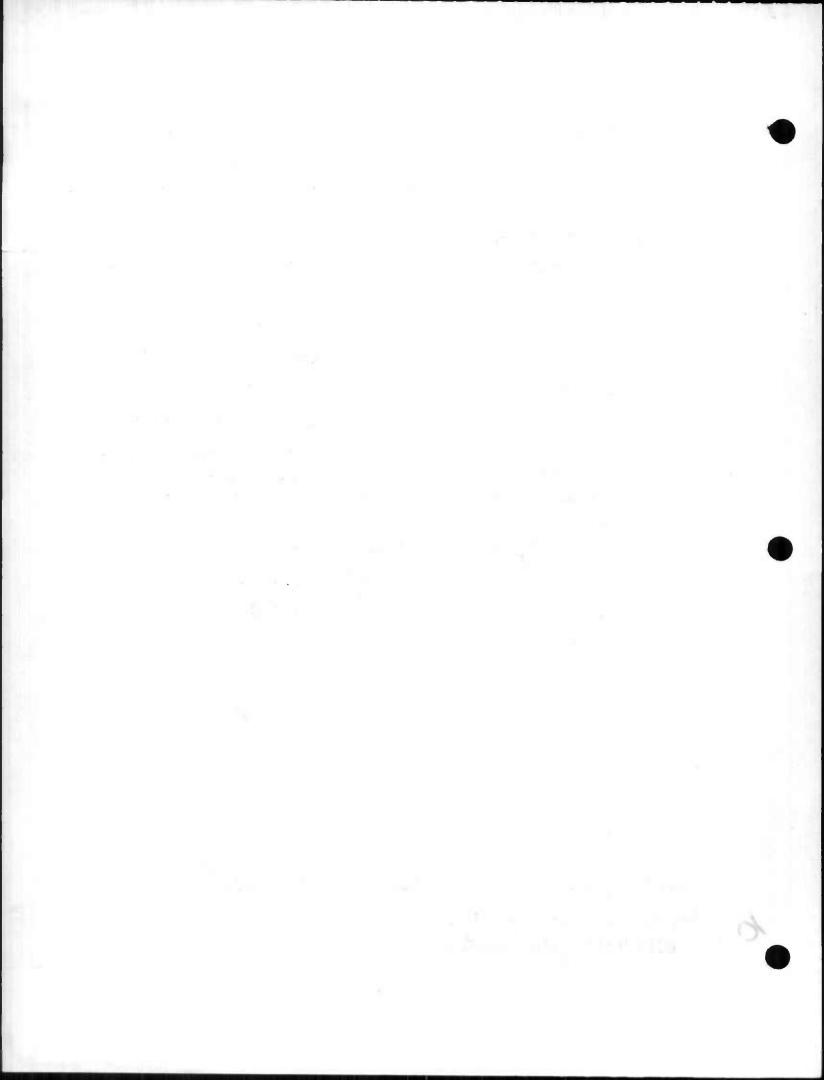


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s be filled within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal. INPORTANT: If them 28 is marked, or them 23 shows any Infury, or other traumatic event. The medical examiner must be notified at once.	
TO THE HOSPITAL OF THE FUNERAL DISPETANT. 14 The	IMI ONLINE OF THE

STATE	0F	MARYLAND	1	DEPARTMENT	0F	HEALTH	AND	MENTAL
		-	10	EDTIFICATE	0	E DEAT	"LD	

FOR 1 • STATE REGISTRAR	STATE OF MARYL	CERTIFIC	CATE OF	DEATH	REG	NO.	
1. DECEDENT'S NAME (First, Middle, Las Basilios	N. Roupas				2. DATE OF DEAMONTH Octobe		3. TIME OF DEATH 95 8:35 P.
4. SOCIAL SECURITY NUMBER 577-05-6500 9a. FACILITY NAME (If not institution, give	1x M 2 F 9!	5 YRS. M	IF UNDER 1 YEAR IONTHS DAYS Bb. CITY, TOWN OF	HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye 10-2-1	900	B. BIRTHPLACE (State or Foreign Country) Grece TY OF DEATH
Presidental Wo			Adelp		LAIN .		ce Georges
Maryland Prin	nce Georges		TOWN OR LOCATE	ON			10d. INSIDE CITY LIMITS? 1 YES 2, NO
100. STREET AND NUMBER 8603 Elm A			101.	20715		10g. CITIZE	U.S.A.
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 NO		olfy Cuban, Maxic	NIC ORIGIN? (Specian, Puerto Rican, et		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12)	DUCATION ade completed) College (1-4 or 5 +)	life. Do NOT use i	rk done during mos retired.)	t of working		F BUSINESS/INDU	
9		Restaura	nt Oper			od Servi	Lce
17. FATHER'S NAME (First, Middle, Last)			-		AME (First, Middle, M		
Nicholas Ro	oupas				erina	Toggas	
Phyllis F. Leps					Route Number, City		code) nia 22309
20a. METHOD OF DISPOSITION		b. PLACE AND DATE OF				, VILGIII	
1X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		metery, cremetory or other Rose C					nsylvania
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			ADDRESS OF F			
> Wallace	S. Brooks		Ruck 1050	Towson York Ro	Funeral ad, Tows	on, Md.	21204
▶ Wallacs 23. PART I. Enter the diseases, c	S- Brooks or complications that cause e. List only one cause on a	ed the death. Do no	Ruck 1050	Towson York Ro	Funeral ad, Tows	on, Md.	21204
23. PART I. Enter the diseases, cahock, or heert failur IMMEDIATE CAUSE (Finel disease or condition	S- Brooks or complications that cause e. List only one cause on a BUE TO (DR AS DUE TO (DR AS) C.	ed the death. Do not each line.	Ruck 1050 anter the mod	Towson York Ro	Funeral ad, Tows	on, Md.	21204 at, Approximate Interval Batwee Onset and Des
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3. TIME OF DEATN

REG. NO.

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Nellie Irene Riddle A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. DATE OF BIRTH (Morth, Day, Year) 12-17-1911 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Fo DAYS 217-76-3761 West Virginia 1 M 2 V F 83 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATN 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Baltimore St. Joseph Hospital Towson RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore Timonium Maryland 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 98 E. Padonia Road, Apt. 202 21093 U.S.A. the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 □ YES 2 ↓ NO Specify: 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Merried BY Specify: 3 K Widowed 4 Divorced White SS ETED. 15. DECEDENT'S EDUCATION 16m. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY nse (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) è Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Homemaker Own Home page 5 should be detached once. 17. FATHER'S NAME (First Middle Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Ħ Maxie Ruckmann Glenn McGinnis notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 14628 Thornton Mill Road, Sparks, Maryland 21152 Elaine C. Tracey pe 20b. PLACE AND DATE OF DISPOSITION (Name of Jessops Meth.) Church Cem. 10-14-95 Sparks, Maryland 20a. METNOD OF DISPOSITION must 20a. METNOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State

4 Donation 6 Other (Specify) funeral director, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ▶ Wallace Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 the the medical 23. PART I. Enter the diseases, or complicati A ... desth. Do not enter the mode of dying, such as cerdiac or reapiratory arrant, Interval Between ŏ filled Onset and Death IMMEDIATE CAUSE (Final the cremation, disease or condition completely resulting in death) other traumatic event, and com CERTIFICATION Sequantially list conditiona, the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or injury that initiated eventa resulting in death) LAST 0 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO эпу signed the 1 TES 2 NO COMPLETION OF CAUSE Shows 1 TYES 2 NO been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. (PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. BEACE OF DEATH (Check only one) Item certificate to the State EXAMINED? HOSPITAL: OTHER: 1 | Inpetient 2 (Carl Outpetient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 84 1 YES 2 NO BY After Investigation 2 Accident 28s. PLACE OF INJURY - At home, farm, street, factory, office DIRECTOR: An hours after desirem 28 is n 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide 29a, CERTIFIER 1 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end menner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho investigation, in my opinion, death occured at BE 9 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2, 3 should

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6 1995

32. REGISTRAR'S SIGNATURE

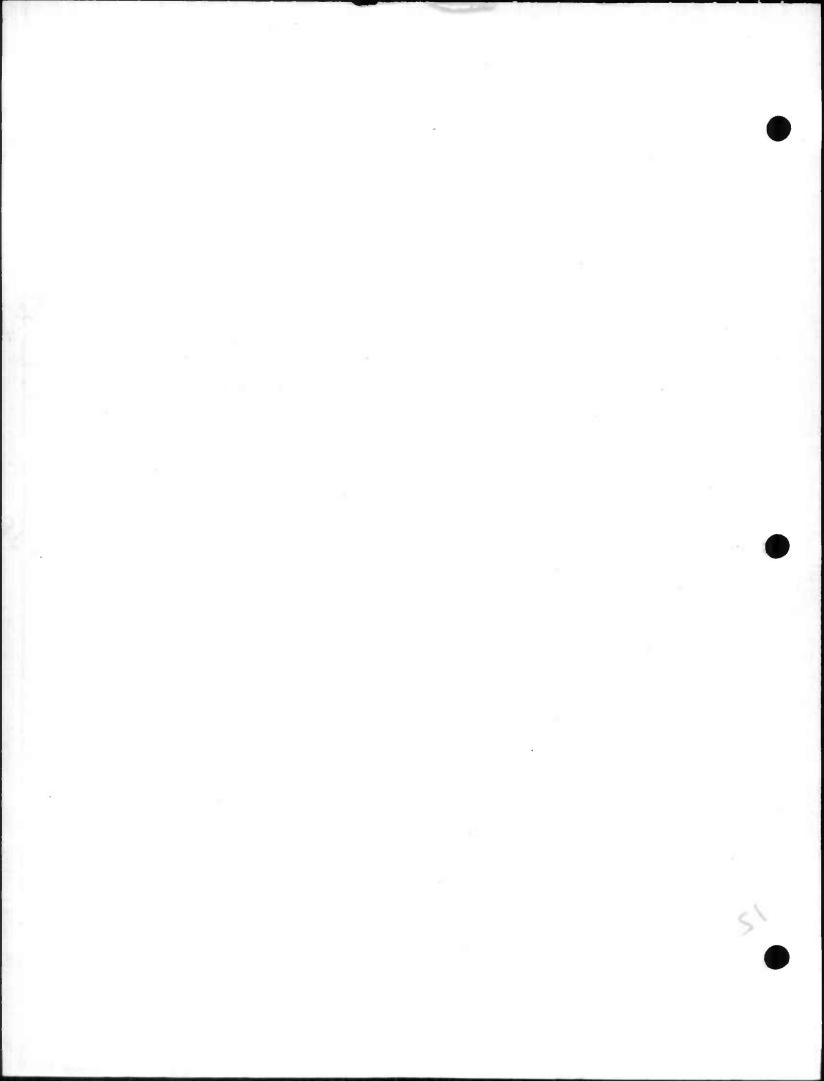
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III.	rtificate has been signed by the attending physician and completely filled in by the funeral of	тар	ic event, the medical
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S	VER	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bun	TANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner mus
E E	FUR	with	TAN

95 31063 ITEM: 25. PER HOSPITAL FILM G-728 10/26/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OFATH YEAR ROBINSON NAOMI 9:16 OCT 995 Μ. PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign OV. 20,1907 218140502 1 - M 2 K F Nov. Maryland 87 Sa. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF OEATH 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR Baltimore Good Samaritan Hospital RESIDENCE OF DECEDENT 10b. COUNTY 10a STATE toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO Md N/A Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 21234 U.S.A. 3409 Rosalie Ave. 12. WAS OECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☑ NO IF YES, OIVE WAR OR OATES X 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, Whita, stc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 YES 2 NO Specify: Specify: 87 3√XWidowed 4 □ Divorced 16b. KIND OF BUSINESS/INDUSTRY COMPLETED tea. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. OECEOENT'S EOUCATION (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Hospital 10th N/A notified at once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George W.Schneider Mary George BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Mrs. Elizabeth Krause 3409 Rosalie Ave. Balto., Md. 21234 å 20s. METHOD OF DISPOSITION

↑ Burlal 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Parkwood Cemetery 10/17 Balto., Md. 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUHERAL SERVICE LICENSEE Hartley Miller Funeral Home De 7527 Harford Rd. Balto., Md. 21234 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart fellure. Liet only one cause on each line. Onset and Death IMMEDIATE CAUSE (Finel the disease or condition resulting in death) ardiogenic event, OUE TO (OR AS A CONSEQUENCE OF): 23 shows any Injury, or other traumatic MEDICAL CERTIFICATION o coril Sequentially list conditiona, OUR TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO t YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL or item HOSPITAL:
11 inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 XXNO 4 Nursing Homa 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 26a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO ВУ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicida 261. LOCATION (Street and Number or Rural Route Number, City-or Town, State) COMPLETED 6 Could not be 4 Homicide IMPORTANT: If item 28 CERTIFYINO PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29 LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) BE

OHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It be filled with it has state bept. of Health and Mental Hygiene prior to burial, cremation, or removal.	DSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Faster death with the State Deor of Health and Mental Hydiana noicr to hurial cremation or named.	
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	1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	TMENT OF	HEALTH AND	MENTAL HYGII		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN		3. TIME OF DEA
- 1	WALTER KURT SC				OCTOBER 10, 1995				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or F
	218-01-6610	1 M 2 D F	81	YRS.	MONTHS DAYS	HOURS MIN.	SEPT. 14	1914	MARYLANI
	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOWN	OR LOCATION OF D			NTY OF DEATN
DIRECTOR	413 HAZLET AVENU		BALTI			N/A			
E C	10s. STATE 10b. COUNT	10c. CITY	TOWN OR LOC	ATION			10d. INSIDE CIT		
	MARYLAND N/A				LTIMOR	E			LIMITS?
A	10e. STREET AND NUMBER				1	01. ZIP CODE		10g. CITI	ZEN OF WHAT COUNTRY?
E	413 HAZLET AVENU	E				21229			U.S.A.
FUNE	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13. WAS DE		NIC ORIGIN? (Specify		14. RACE — American Ind
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1		10	If yes, s	S 24 NO Specific	an, Puerto Rican, etc.)		Black, White, etc. Specify:
8	15. DECEDENT'S EDU	ICATION	Ma DE	CEDENTIE	USUAL OCCUPAT	TON	401 9910 051	1	WHITE
E	(Specify only highest grade	completed)	(Gi		ork done during n		16b. KIND OF	SUSINESS/IND	PUSTRY
COMPLE	College (1-4 or 5+)						CEI	F EMPI	OVED
8	8 17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, Maid		OLED.
O H	PAUL SCHMIDTCHEN								
8	19s. INFORMANT'S NAME (Type/Print)		4ns	MARINO	ADDRESS (Ob		T. SCHIL		2.4
유	PAULETTE S. TOWNSHEND 19b. MAILING ADDRESS (Street and Number or Paral Route Number, City or Town, State, Zip Code) 6607 LOCHINVAR DRIVE, CATONSVILLE, MD 21228								
	20a. METHOD OF DISPOSITION				F DISPOSITION //				City or Town, Btate
.	1 Donation Rome Rome Rem	NTOMENTAL	cemetery crer	matory or other	her place!				
1	21. SIGNATURE OF PUNDINAL SUPPLICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								
LOUDON PARK FUNERAL HO								OME. 1	INC.
	1600 8	· Puo	2					ORE, MD 212	
	23. PART I. Enter the diseases, or					, 11 TIMETHO	WARMORE		TORE, THE ZIA
	abook or brood follows	complications that	caused the day	ath. Do n	ot antar the m	oda of dying, suc	ch as cardiac or re	piratory arm	est, Approxim
	anock, or naart failure.	List only one cause	caused tha dar e on each line.	eth. Do n	ot antar the m	oda of dying, suc	ch as cardiac or res	piratory arm	est, Approxim
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	IMMEDIATE CAUSE (Final	List only one cause	on aach lina.		ot antar the m	oda of dying, suc	ch as cardiac or res	piratory arm	est, Approxim
	IMMEDIATE CAUSE (Final disease or condition	List only one cause	caused tha date on each line.		ot antar the m	oda of dying, suc	th as cardiac or rea	piratory arm	Approxim Interval B Onset and
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ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. DUE TO (O	on aach lina.	C (U	ot antar the m	oda of dying, suc	ch as cardiac or re	piratory arm	Approxim Interval B Onset and
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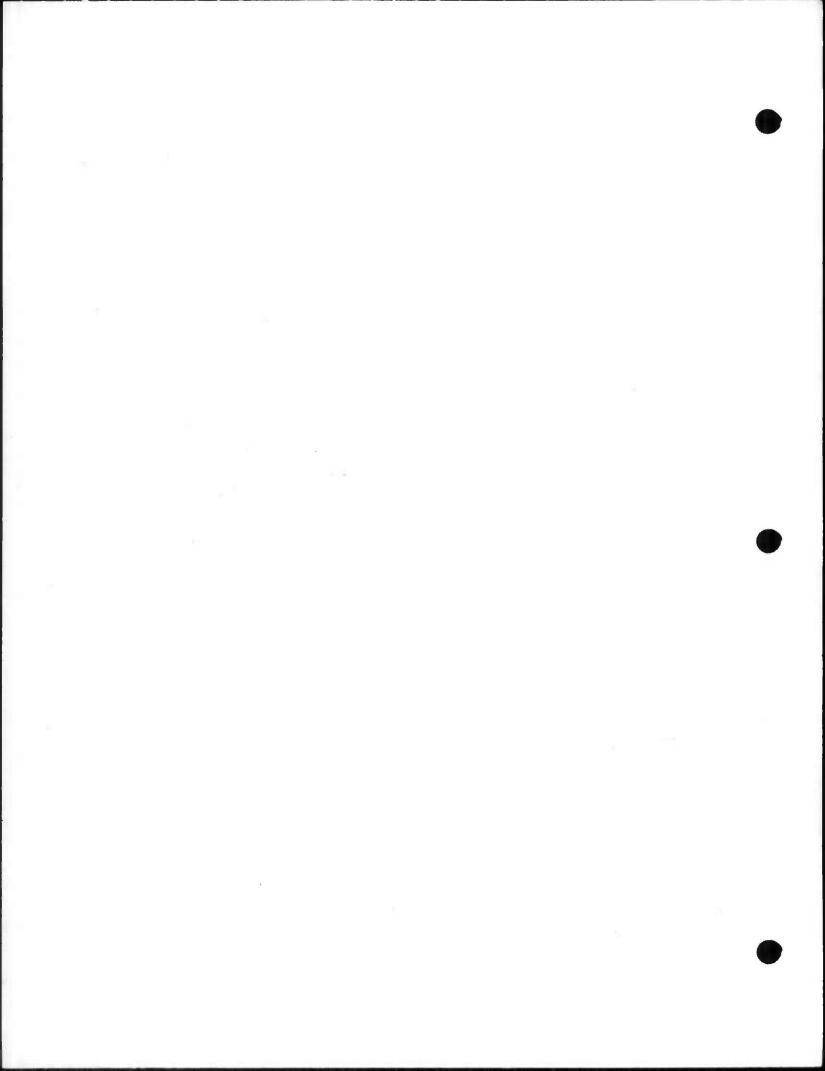
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CATON AVE

BALTIMONE MOZIZZ9

31. DATE FILED (MOSIP), Day, Year)

OCT 1 6 1995



Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 after death.

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31. DATE FILEO (Month, Day, Year) OCT 1 6 1995

30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Ma il san Rag

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cremation,

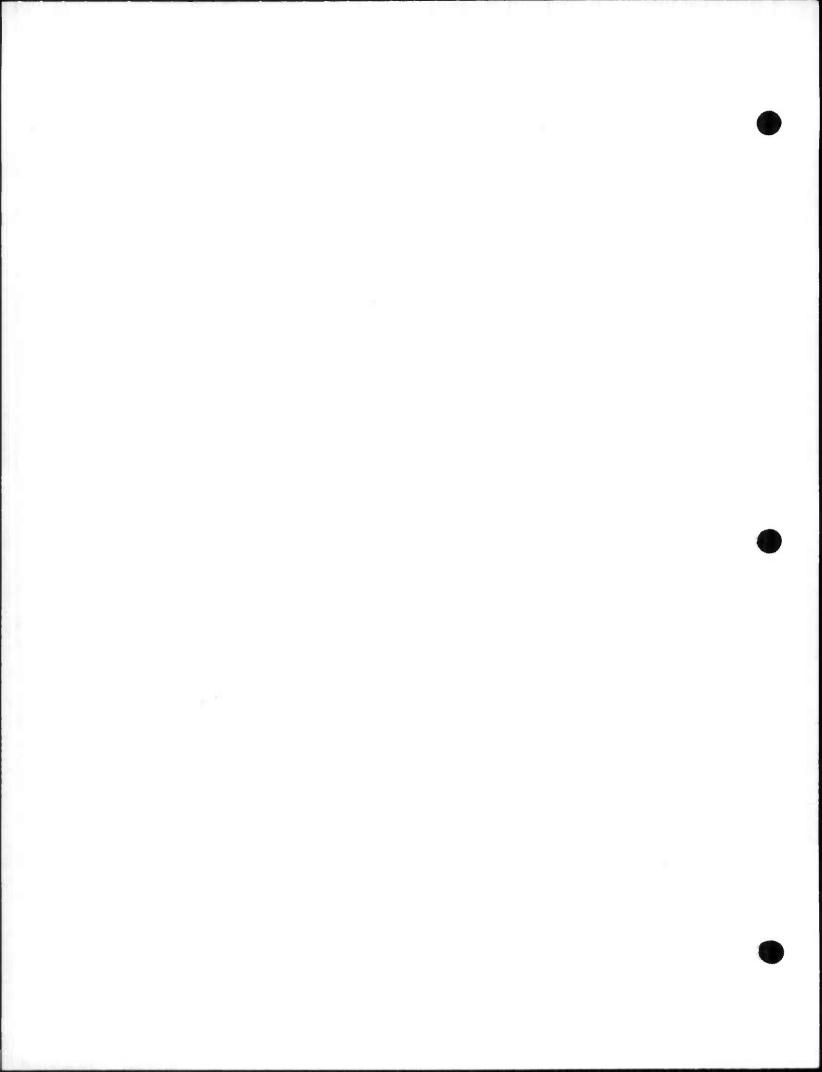
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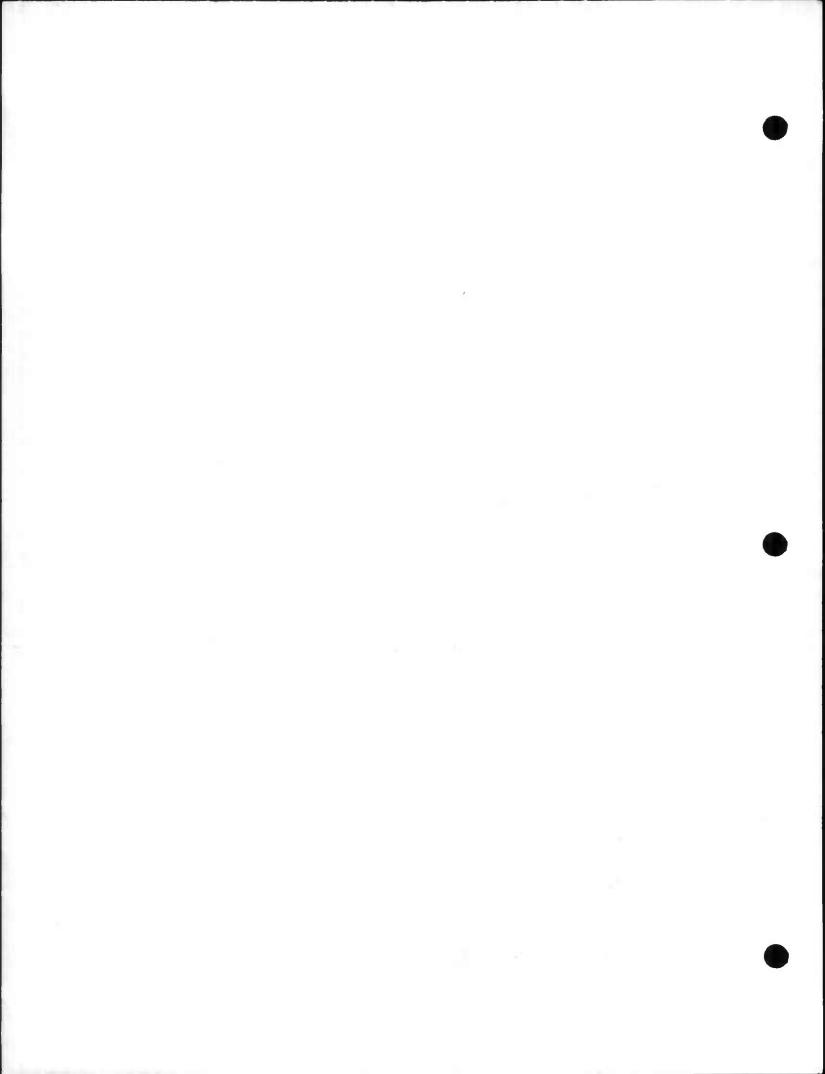
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH RIEda Smith ActobeR 95 12:65 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
JULY 28, IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign Country) 216-05-5981 MONTHS DAYS HOURS 1 - M 2 XF 83 YRS Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Caton Manor Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 102 S. Carrollton Ave. 21223 USA 11 MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 3 Widowed 4 Divorced BY Specify: white 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11 N/A Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick Seward te Lydia BE Zwanzger notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lydia Mason 5721 Edmondson Ave., Catonsville, Md. 21228 Pe 20e, METHOD OF DISPOSITION
1 (\(\Delta \) Burlal 2 \(\Delta \) Cremation 3 \(\Delta \) Removal from State 10/₁ 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must cametery, cremetory of other place)
Meadowridge Memorial Park 4 Donation 5 Other (Specify) Elkridge, Md. 21. SIGNATURE OF EUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Hours Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on each lina. interval Between IMMEDIATE CAUSE (Final **Onset and Death** the SEASLS disease or condition event, resulting in death) well DUE TO (OR AS A CONSEQUENCE OF): raumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 6 injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part II. 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS DEMENTIA shows any AVAILABLE PRIOR TO COMPLETION OF CAUSE t TYES 2. TH 1 YES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) Item HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA sing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 5 Pending м 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — Al home, term, streat, factory, office building, atc. (Specify) 69 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide item 29s. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated, TO THE HOSPITAL (TO THE FUNERAL DE FILED WITHIN 72 TO THE MINING TO THE MINING TO THE FIRED THE MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SCHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year)



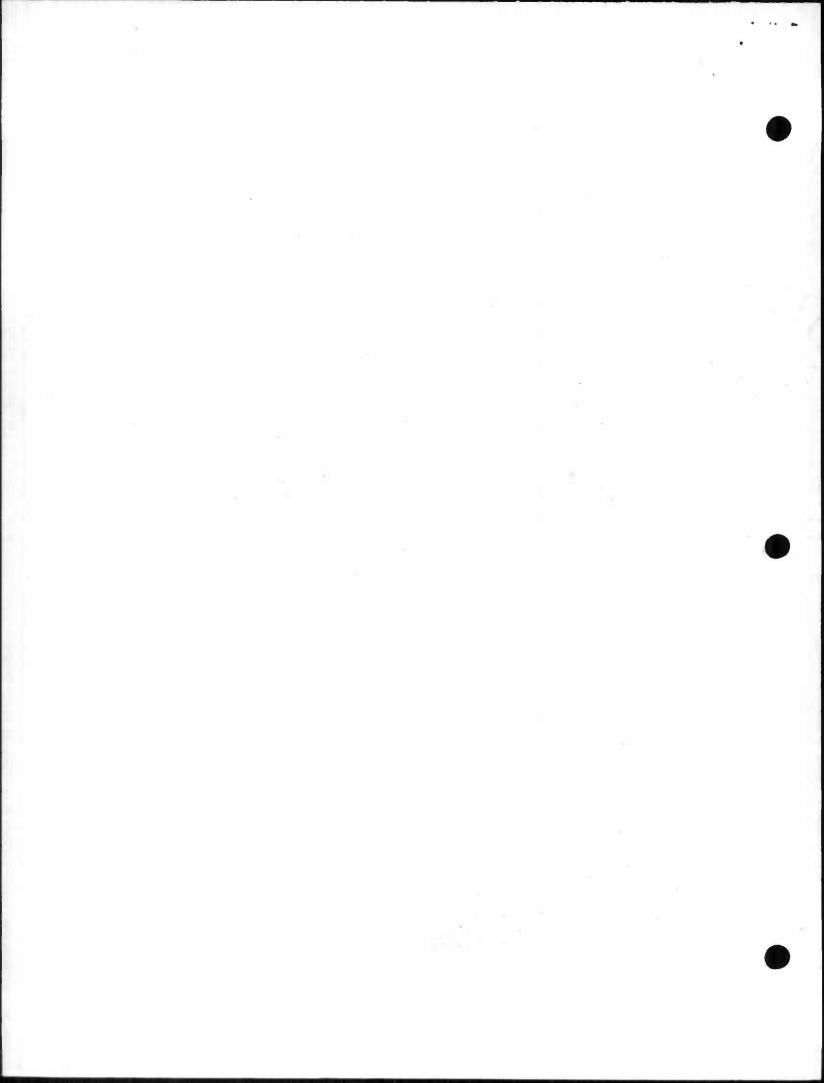
	_	1 - FOR REGISTRAR		MARYLAND C	DEPAR	RTMENT (F HEAI	LTH AND I	MENTAL HYGIE REG. N			
		1. DECEOENT'S NAME (First, Middle, Last) Henry Alonda Sneed				Sr.			2. DATE OF DEATH DAY YEAR 10 12 1995			7: 00 Pm
Pi	ls.	4. SOCIAL SECURITY NUMBER 246-30-0611 9e. FACILITY NAME (If not institution, giv	5. SEX	6. AGE (In yrs. In 72	st birthday) YRS.		AYS HOL		7. DATE OF BIRTH (Month, Day, Year) 4-23-1923		Country) Johns	ton N.C.
2, 3 should	CTOR	2520 W. Coldsp		96. CITY, TOWN OR LOCATION OF DEATH Baltimore N/A								
. Pages 1,	DIREC	10e. STATE 10b. COUL	N/A			y, town on D					- 1	IOd. INSIDE CITY LIMITS?
sit permit.	AL	100. STREET AND NUMBER 2520 W. Coldspi			1 0	101. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY?		
5-UUZU nding physician. Is the bunal-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN	YES 2	RMEO NO	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify:			- American Indian, White, etc.			
D 2121 pital or atte ed for use a	APLETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12) 3rd .	OUCATION de completed) Cotlege (1-4 or 5 + N/A	(0	Weld		PATION ng most of v	working	16b. KIND OF B	usiness/ino	USTRY	DidCk
of the be dell	BE COMPL	17. FATHER'S NAME (First, Middle, Last) York Sneed						Lula	ME (First, Middle, Meide Hodaes	on Sumama)		
or retain be retain ge 5 sho	2	190. INFORMANT'S NAME (Type/Print) Henry Sneed			16 St	efanie	Ct.	Winc	hester KY	40393	1	
e 6 m		20a. METHOD OF OISPOSITION 1/ Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF OISPOSITION (Name of cometery, crematory or other piece) Hamilton Burial Garden 22. NAME AND ADDRESS OF FACULTY 22. NAME AND ADDRESS OF FACULTY										
death fune fune		Feis ?	Gary L. Kaufman Funeral Home of Elkridge,									Elkridge,
executed within 24 hours after and completely filled in by the o burial, cremation, or removal malic event, the medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Ones as a consequence or)										
th certificate be execu- ending physician and if Hygiene prior to bun or other traumatic	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): 4. DUE TO (OR AS A CONSEQUENCE OF): 1. DUE TO (OR AS A CONSEQUENCE OF): 4. DUE TO (OR AS A CONSEQUENCE OF): 1. DUE TO (OR AS A CONSEQUENCE OF):										
requires that the sen signed by the of Health and Me shows any inju	MEDICAL C	PART II. Other aignificant conditi	one contributing to	deeth but not i	reculting		/		Part I. 24s. WAS A	IN AUTOPSY DRMED?	24b. W	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
The lanter has ate Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		OF OEATH (Che	ack only one) 8 Other (Specify)			
F with F	ву Рну	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF (Month, Da	INJURY	28b. TIM	E OF 280 URY	WORK?	AT .	28d. OESCRIBE HOW	INJURY OCC	URED	
CTOR: A after de 28 is	ED	3 Suicide 8 Could not b 4 Homicide determined	28a. PLACE OF building, (INJURY — At ho ntc. (Specify)	me, farm, s	street, factory,	offica		281. LOCATION (Stree City or Town, State	t and Number e)	or Rural Rou	ite Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours	COMPLET		SICIAN: To the best of o									nd manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	TO BE	29b, SIGNATURE AND TITLE OF CERTIF	10, M. I	2.			29c.	LICENSE NUM	263	29d. DATE	SIGNED/(A	fonth, Dly, Year) 4/95
	9	JOYGE F-Tre	10, M.D.	601 N		rint)	e S	5+ R.	m.7161.	Bar	40.1	no 21287
		OCT 1 6 1995	1. Studen									



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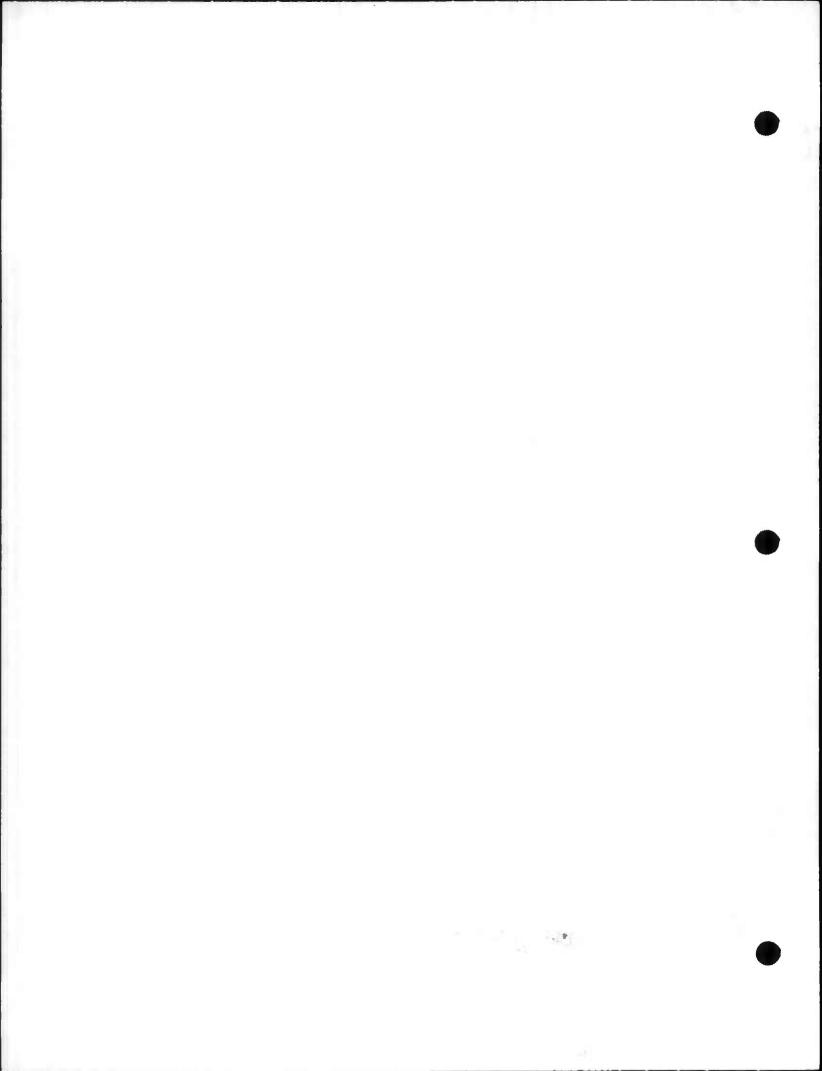
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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4	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Charles	L	Ship	oley.	Jr.	- 1	14 95	9:18 Pm		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In		UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BUTTH	8. BIR	THPLACE (State or Foreign intry)		
	215-07-9109	HOURS MIN.	October 3	,1915 M	aryland					
~	9e. FACILITY NAME (If not institution, give sti		9		R LOCATION OF D	9c. COUNTY OF	DEATH			
DIRECTOR	Good Samaritan Ho	<u>spital</u>		Balti	more, Ci	ty	N/A			
EC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?		
1	Maryland	N.A	Bal	timore,	City			1 X YES 2 NO		
MAL	10e. STREET AND NUMBER			101	ZIP CODE			WHAT COUNTRY?		
FUNERAL	5003 Grindon Ave				21214			.S.A.		
5	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DATE	U.S. ARMED 2 NO	13. WAS DEC	ENDENT OF HISPAI polity Cuben, Mexico	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	e or No- 14. RA Bio	CE — American Indian, ack, Whits, etc.		
₽	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DATE	res	1 TYES	2 NO Specif	y:	Sp	White		
8	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S US	UAL OCCUPATION	N .	16b. KIND OF BU	JSINESS/INDUSTRY	MILLO		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wor life. Do NOT use i		st or working					
MP		1	Invest	agator		Motor V	ehicle A	dministration		
8	17. FATHER'S NAME (First, Middle, Last)	1				ME (First, Middle, Melder		-		
BE	Charles L. Ship	Tey	1			A. Johnson				
5	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox				
	Mary E. Shipley	200	1 3510 PLACE AND DATE OF		mp Ave.		d. 21214 OCATION — City or			
	1 X Buriel 2 Cremetion 3 Remo	oval from State come	teny cremetony or othe	e nlace l						
	21. SIGNATURE OF FUNERAL BERRYICE LIC	eyher.	il etalla M	22. NAME AL	ID ADDRESS OF FA	CILITY		re, Maryland		
	> /2/ 1/ P	11.11		Leon	ard J. F	luck Funera	al Home,	Inc.		
	22 PART I Enter the discourse	wall of the sound	the death. Do not					aryland 21214		
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.									
	iMMEDIATE CAUSE (Final disease or condition	Sand	1	_				Onset and Death		
	reaulting in deeth)	DUE TO OR AS A	CONSEQUENCE OF:	eum		Imonth				
_	Cercho varcular Accident									
9	Sequentially list conditions,		CONSEQUENCE OF):		10010			Month		
S	cause. Enter UNDERLYING CAUSE (Disease or injury	n.								
ᄩ	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE DF):							
CERTIFICATION	resulting in death) Exist	d								
AL C	PART ii. Other aignificent conditions	a contributing to deeth bu	it not resulting in	the underlyin	cause given in			4b. WERE AUTOPSY FINDINGS		
EDIC/						1 YES	2 5€ NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEC								1 YES 2 NO		
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAI	N 🔀				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	R. PLACE OF DEATH	(Check only one)						
YSI	1 YES 2 NO	t XInpatient 2 - ER/Outpe			e 5 🗆 Reeldence	8 Other (Specify)				
РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	26b. TIME INJUS	YY WC	RK?	28d. DEŞCRIBE HOW	INJURY OCCURED			
B	2 Accident Investigation	DO DI ACE OF IN HIDY			rES 2 NO					
B	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	At nome, term, str	eet, lectory, offic	•	281. LOCATION (Street City or Town, State		al Route Number,		
	29e. CERTIFIER									
MP	(Check only	CIAN: To the best of my knowle						of a seal management		
MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner										
BE	296. SIGNATURE AND TITLE OF CERTIFIER	N.D			P 76			ED (Month, Day, Year)		
25	ME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type P	rint)						
	Ali Saifi Good Sav	maritan Hosp,	5601 Loc	n Raver	Blud.	Balling	ore. MD	21239		
	31. DATE FILED (Month, Day, Year)	32 REGISTRATES SONA	TURE							
	OCT 1 6 1995 A	. Huderhad	GALL.							



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		1 . STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMI			MENTA	AL HYGIEN	Ε				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	E OF DEATH	av.	VEAD 3.	TIME OF DEATH		
			IMMONS					0 13	3 9	SEAR .	2:20 PM.		
P		218-26-3463	1 M 2 K F 64	MONT	HB DAYS	IF UNDER 24 HRS. HOURS MIN.		th, Day, Year)		Country) Mary	ACE (State or Foreign		
3 should	oc.	Se. FACILITY NAME (If not institution, give stre			CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNT	Y OF DEAT	гн		
1, 2, 3	DIRECTOR	Stella Maris Hospice-Mercy Hospital Baltimore N/A											
	REC	10e. STATE 10b. COUNTY		10c. CITY, TOV	WN OR LOCA	TION				10	d. INSIDE CITY		
permit. Pages			ne Arundel	G1	len Bu	ırnie				1	LIMITS?		
t perm	PAL	10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZE	N OF WHA	AT COUNTRY?		
ian. transi	FUNERAL	113 Martha Road	40 1000 0000000000000000000000000000000	T		21061			Unite				
21215-0020 al or attending physician. for use as the burial-transit	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE	NO	If yes, sp	CENDENT OF HISPA Hecify Cuben, Mexic 3 2 NO Speci	en, Puerto		or No- 1		American Indian, white, etc. White		
1215 r attend use as	品	15. DECEDENT'S EDUCA (Specify only highest grade of	a. DECEDENT'S USUA	L OCCUPATION	ON	16	b. KIND OF BUS	SINESS/INDU:	STRY	WILLCE			
21 21 21 21	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work d life. Do NOT use retin Homemake	ed.)	ost of working		Own Ho	me				
YLAND 2 by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Y L	BE C	Frank Beczkows	reled					ura Arendt					
MARYLAND retained by the hospit 5 should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	RESS (Street a				n, State, Zip C	iode)			
E, M y be re lage 5		Mrs. Kathleen Eva	ns	7834 Tel	egrap	h Rd. Se	vern	, MD 2	1144				
C E 5 5		20a. METHOD OF DISPOSITION 1 Remove the property of the prope	rai from State cometer	ACE AND DATE OF DIS	POSITION (Na	ame of	DAT	TE 20c. LO	CATION — CI				
MC direct		4 Donation 5 Other (Specify) 21. SIGNATURE/OF FUNERAL SERVICE LICE	Gle	n Haven M	iem. P	k. Oct.	16,	1995	Glen E	Burni	e, MD		
BALTIMO after death. Page 6 by the funeral directs moval. cal examiner mu		De l'ani	Ebange	/.		ey-Ruddi		uneral	Home				
0 - 0		COU a.			421 C	rain Hwy	. S.	E. Gle	n Burr	nie,	MD 21061		
ed in the			ist only one ceuse on each	e desth. Do not er line.	nter the mo	ode of dying, aud	h sa car	diec or respi	ratory srres	it,	Approximate Interval Between		
등 등 등		IMMEDIATE CAUSE (Final disease or condition resulting in death)											
ted within 4 completely fille fal, cremation, event, the		resulting in death) s.	DUE TO (OR AS A CO								14 mos.		
	z												
× 8 E BE	RTIFICATION	Sequentially list conditions, If any, leading to immediate											
B be by at m	2	CAUSE (Disesse or Injury	DUE TO (OR AS A CO	NSEQUENCE OF									
	Ē	that initiated events resulting in death) LAST	DOE TO (ON AS A CO	NSECUENCE OF):									
0,0 =	S	d.											
E = 0 = -	MEDICAL	PART II. Other significent conditions	contributing to death but i	not reaulting in the	underlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR		AM	ERE AUTOPSY FINDINGS AILABLE PRIOR TO		
RECO requires the een signed of Health a	ä							1 - YES 2	NO		MPLETION OF CAUSE DEATH?		
		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF I	DEATH YES T	I NO E	T LINICEDTAL	N D			1 (YES 2 NO		
N 6 8 5 7	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (Ch		OITCLKIA							
OF VITA PHYSICIAN: The this certificate hi with the State Directory or Item	SIC		HOSPITAL: 1 Inpetient 2 ER/Outpatie	nt 3 DOA 4 D	TER: Nursing Hom	e 5 🗆 Residence	6 XOth	er (Specify) H	OSPIC	E			
PHYSICIA this certi with the riked, or	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJ		T	SCRIBE HOW IN					
ON O DING PHYS After this death with	B	1 Netural 5 Pending 2 Accident Investigation			1 🗆	YES 2 NO							
		3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, street,	factory, offic	•		ATION (Street a or Town, State)	nd Number or	Rural Rout	e Number,		
OR ATTEN OR ATTEN OIRECTOR: hours after Item 28 I		29a, CERTIFIER											
4 7 Z	COMPLET	(Check only	AN: To the best of my knowledg On the beals of exemination an	a, death occurred at ti d/or investigation, in r	he time, data ny opinion, d	and place, and due leath occured at the	to the ca	use(e) and men a end place, end	ner as stated d due to the o	cause(a) an	d manner as stated.		
E HO		29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU		Т			onth, Qay, Year)		
TO THE HOSPIT TO THE FUNERA De filed within ?	TO BE	Di.	Minimo			DYO	DY0480 > 10/14/93			195			
	=	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)		BELN		MO.			***************************************		
<				Del A - A	BAL	TO , MD	2	1206					
		OCT 1 6 1905	32 FEBISTRANS SIGNATUR	Rardall									



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FilmG. 728, item #7,19b, 10/16/95,cyw, per f.h.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Lest)					2. DATE OF OEATN	AY YEA	3. TIME OF DEATN	
	SAMMIE E	•	TE	RRY		OCT.11,	19:03 P M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yr		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH J	ANT RE	BITNEL ACE (State or Formion	
	220-50-0622 1 □x M		SAY C	NTHS DAYS	HOURS MIN.	JAM. 15,19	950 N.		
	9a. FACILITY NAME (If not institution, give street and n	umber)	98	. CITY, TOWN	OR LOCATION OF DE	ATN	9c. COUNTY (
STOR	JOHNS HOPKINS HOSPITAL BALTIMORE n/a								
DIRECTOR	MARYLAND 10b. COUNTY n/a		10c. CITY, T	BALTII				10d. INSIDE CITY V LIMITS? 1 YES 2 NO	
FUNERAL	1903 E. 31 st str	eet		10	21218		UNITE	D STATES	
BY FUN	1V V Neuer Married 2 Married FOR	DECEDENT EVER IN U.S DES? 1 TYES 2 S, GIVE WAR OR DATES	∀ No	If yes, sp	ENDENT OF NISPAN ecify Cuban, Maxicar 2 (1) NO Specify		1	RACE — American Indian, Black, Whita, atc. Specify: BLACK	
	15. DECEDENT'S EDUCATION	166	. DECEDENT'S US	JAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUST	RY .	
COMPLETED	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4 or 5 +)	(Give kind of work life. Do NOT use re SANIT	tired.)	WORKER	RALT	IMORE	CITY	
MD	17. FATNER'S NAME (First, Middle, Last)	years	SANTIA	RITON		ME (First, Middle, Melden		CITT	
BE C	SAM C. TERRY JR.				LULA	HIGHSMIT			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street	and Number or Rural F	oute Number, City or Tow	n, State, Zip Code)	
F	JUANCHULLA TERRY		1903	Ε.	31 st -	STRET, BAI	TIMORE	, MD 21218	
	20s. METNOD OF DISPOSITION 1X] Burlai 2 Cremation 3 Ramoval from State 4 Donation 6 Other (Specify) 20s. METNOD OF DISPOSITION (Name of commettery, crematory or other place) KING MEMORIAL PARK 10-17 RANDALLSTOWN								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	7)			NO ADDRESS OF FAC				
	1/anste Co	4		WM.	C. MARCH	FH.p -1	101 E.	NORTH AVENUE	
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ACUTE COCAINE AND NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF):								
ERTIF	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEOUENCE OF):						
	PART II. Other algnificent conditions contril	outing to death but	not resulting In t	he underlyln	g cause given in	Pert I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
DICAL				Ť		PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ш					<u></u>	YES 2	I NO	OF DEATN?	
Σ	DID TOBACCO USE CONTRIBUTE	TO CALISE OF I	DEATH VEC		UNCERTAIN		ŀ	1 YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATN (
PHYSICIAN:	EXAMINER? HOSP	ITAL:	0	THER:		- 22 25			
₹		. DATE OF INJURY			JURY AT	8 Other (Specify) 26d. DESCRIBE NOW	NUME OCCUPE		
	1 Netural 5 Pending	(Month, Day, Year) 0-11-95 FOUND	FUUNDA 6:19 P	M 1	DRK?	SUBJECT ING			
D BY	3 Suicide SXX Could not be	PLACE OF INJURY — building, atc. (Specify)		et, factory, offic		26f. LOCATION (Street City or Town, State)	and Number or R		
E E	4 Nomicide determined		UNKNOWN	TF.		UNKNOWN			
COMPLETED	298. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To 1 MEDICAL EXAMPLER: On the							use(a) and manner as stated.	
TO BE C	296. HOMATURE AND TITLE OF CENTARIER	ETED CAUSE OF DEATH	Dyl		296. LICENSE NUN OCME			C.12,1995	
	MARIO + GOLVE.	JR-MHS.	lll Pen		eet, Ba	ltimore,	Mary	land 21201	
	31. DATE FILED (MONT), 12. 16 1995 32	HEGISTRAN'S SIGNATU	Farfall						

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MA 32. REGISTRAT'S SIGNATURE

FilmG, 728, item #10f,10g, 10/16/95.cyw, per f.h. 95 3 070 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 35 01 10 214-26-6173 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) S. BIRTHPLACE (State or Foreign S. CAROL INA IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 M DAYS HOURS MIN. 72 YRS. 1923 7, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, UNIVERSITY 96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 9c. COUNTY OF DEATH HOSPITAL DIRECTOR n/a RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY VIMITS? 1 YES 2 NO BALTIMORE MARYLAND n/a permit. 10s. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? STATES 21207 UNITED 1717 BRUNT STREET Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 X Never Married 2 Married BY Specify: BLACK 3 Widowed 4 Divorced ETED. 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired,) Elementary/Secondary (0-12) College (1-4 or 5 +) LABORER - unemployed COMPL various trades once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at CENTRAL MILLS CLASSICE ROUNDTREE BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 LYNELLE CAHTMAN 831 HARL EM AVENUE, BALTIMORE, MD 21207 pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must XX Buriel 2 Cremation 3 Removal from State the funeral director, VOSHELL MEMORIAL ☐ Donation 5 ☐ Other (Specify) GARDENS DUNDALK, MARYLAND medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. WM. C. MARCH FH.-1101 E. NORTH A VENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, and completely filled in by burial, cremation, or remo Approximate ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition_ Stace VIB ance Varian resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION em.a Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) prior to l if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury physician other t DUE TO (OR AS A CONSEQUENCE OF) that initiated events. has been signed by the attending Dept. of Health and Mental Hygier resulting in death) LAST 0 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS amy AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 AND shows : 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL:
1 Compatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural . DIRECTOR: After the hours after death w 1 YES 2 NO BY 2 Accident investigation 3 Sulcide 28a. PLACE OF INJURY -- At home, farm, street, factory, office * 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Item 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atsted. FUNERAL I = 2 MEDICAL EXAMINER: On the basts of examination and/or investigation, in my opinion, death occurred at the films, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITY
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER B 29d, DATE SIGNED (Month, Day Year) 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

__

	1 - FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF	MAHYLAN	CERTIF						REG. NO	E	1.	
- 8	Estello		Tseledis					MONTH DAY A YEAR			10:35 N		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. lest birthday)	IF UNDER	-	#F UNDER	24 HRS.	7. DATE	OF BIRTH	1		ACE (State or Foreign
- 1	219-05-0981	1 M 2 T F	88	YAS.	MONTHS	DAYS	HOURS	MIN.	Oct	15,19	06	Gre	ece
œ	90. FACILITY NAME (If not institution, give a Bon Secours Hosp	,					on Locatio		ATH			TY OF DEA	TH
СТОЯ	RESIDENCE OF DECEDENT	TOTI	lore (o I ty				N/A					
DIREC	10s. STATE 10b. COUNT				ry, TOWN							1	0d. INSIDE CITY LIMITS?
	Maryland N/A	<u> </u>		Ва	.ltim		City					1	TYES 2 NO
ERAL	100. STREET AND NUMBER 1 W. Conway Stre	at Ant	1108			10	1. ZIP CODE	201				ZEN OF WH	AT COUNTRY?
FUNE	11. MARITAL STATUS					WAS DEC			IIC OBIGI	N2 (Specify Voc			- American Indian.
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? IF YES, GIVE	T YES 2	NO ON	NO If yes, specify Cuban, Maxican 1 YES 2 NO Specify:			en, Puerto Rican, etc.) Black,			Bleck, \	White White	
TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16	a. DECEDENT'S				10	160	b. KIND OF BUS	SINESS/IND	USTRY	
PLET	Elementary/Secondary (0-12) College (1-4 or 5+)			Manager		itired.)		Venetian Bli		ind Mfg			
COMP	17. FATHER'S NAME (First, Middle, Last)			Tanage	.T		18. MOTH	IFR'S NA		Middle, Maiden		LIICE II.	6
ш	George Thamagos									aris	00111011107		
TO B	19a. INFORMANT'S NAME (Type/Print)			1						nber, City or Tow			
-	Catherine Wagner	•		l W.	Conw	ay S	tree	t, B	alti	more,	Md. 2	21201	
	20g METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem	ioval from State	cemeter	ACE AND DATE y, crematory or o	ther plecel				DAT			City or Town	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	- I Gre	ek Ort			METE:			10 Bal	timon.	ce, Mo	1.
j.	Matthews Funeral Home										07.001		
-9	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	anock, or haert failure. List only one ceuse on each line. Interval Betw										Interval Between Onset and Death		
Σ	disease or condition resulting in death) Due to (or as a consciouence of):										1 week		
NO	Sequentially list conditions, Diff TO (OR AS A CONSEQUENCE OF)												
TA	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):											
RTIFICATION	CAUSE (Diseese or Injury that initiated events	c. DUE TO	(OR AS A CO	NSEQUENCE O	F):								
CERT	reaulting in death) LAST	d											1
4	PART II. Other algnificant condition	na contributing to	death but	not recuiting	in the ur	nderlyin	g cause g	iven in	Part I.	24s. WAS AN		24b. W	ERE AUTOPSY FINDINGS
MEDICA	- try high	eng 1	anal	facle	we					PERFOR	-	0	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
ME													YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL												
SICIAN:	EXAMINER?	HOSPITAL:	EB/Outpetle	a 2 🗆 504	OTHER	R:	LACE OF DE						
PHY	27. MANNER OF DEATH	28e, DATE OF	FINJURY	28b. TIA	E OF	28c. INJ	URY AT	sidence		SCRIBE HOW II	NJURY OCC	URED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, E	July, rear)	in.	JURY		YES 2	NO					
	3 Suicide 6 Could not be determined	28a, PLACE (building	of INJURY — . atc. (Specify)	At home, term,	street, tact	lory, offic	•			CATION (Street a or Town, State)	nd Number	or Rural Rou	te Number,
E	29a. CERTIFIER			aduce Tier	VVC								
COMPLET	(Check only one) 2 MEDICAL EXAMINE												nd manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICE						Ionth, Day, Year)
3BE	Draw	Nus					0	200	040	0	> /	0/9	185
2	D. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Time Print)						10/1/0						

ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is *marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

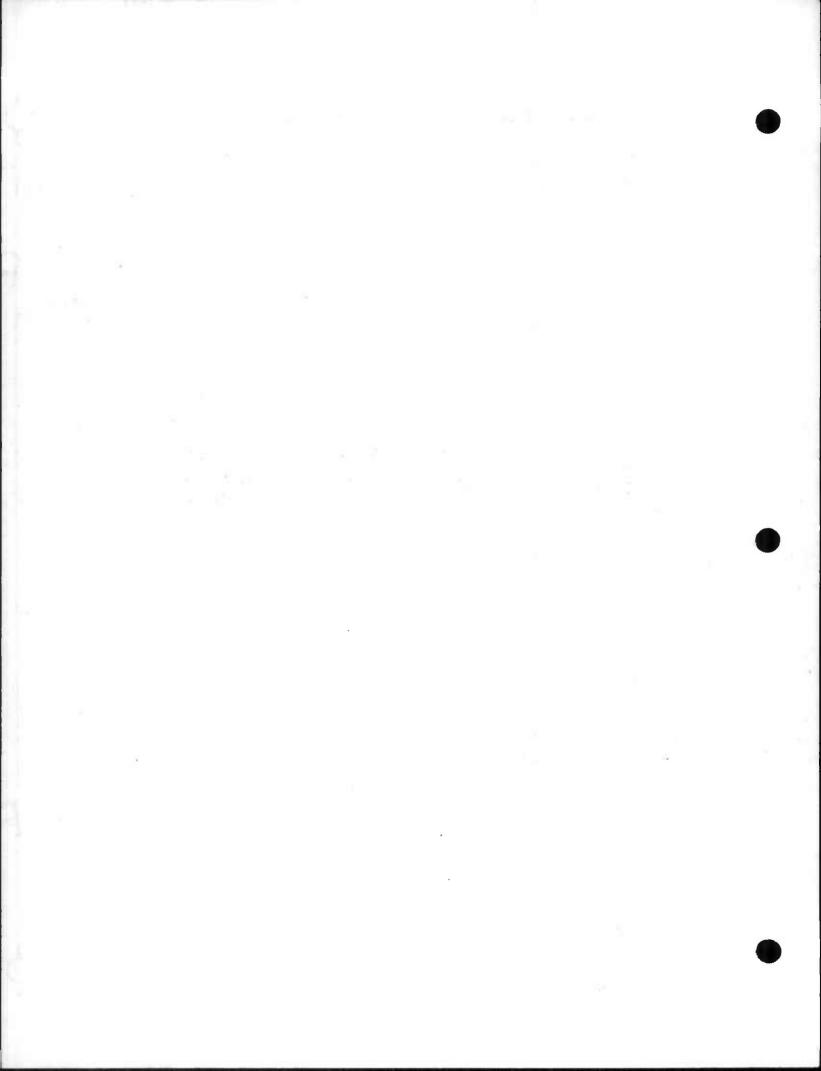
DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	STATE OF MARYLAND / D	EPARTMENT OF		MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN	DAY YE	3. TIME OF DEATH					
	HARRY	TARLETON			OCT. 10		9:42 P. M					
	4. SOCIAL SECURITY NUMBER 248 - 78 - 7745 T	5. SEX 1 M 2 F 6. AGE (In yrs. lest bit)	YRS. HONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)	10.0	SIRTNPLACE (State or Foreign Country) Md					
(m	99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWH OR LOCATION OF DEATH 1 TDEDTY MEDICAL CENTED DAITTMODE											
CTO	RESIDENCE OF DECEDENT											
DIRECTOR	md NA Balto 1X YES 2 NO											
FUNERAL	2229 Poola	- Grove :	st.	21211		10g. CITIZEN	S . A					
5	11. MARITAL STATUS	12. WAS DECEOENT EVER IN U.S. ARME FORCES? 1 YES 2 NO			HC ORIGIN? (Specify Ye	na or No— 14.	RACE — American Indian, Black, White, alc.					
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		apecify Cuban, Mexica ES 2 NO Specify			Specify: Black					
	15. OECEDENT'S EDUC (Specify only highest grade		DENT'S USUAL OCCUPA kind of work done during		16b. KIND OF BU	JSINESS/INDUST	RY					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	NOT use retired.)	most or working	Car	pente						
OMP	17. FATNER'S NAME (First, Middle, Lest)	xyrs Ca	rpentry	16. MOTNER'S NA	ME (First, Middlp, Maide							
BE C	Hams J. T	arleton Sr.		Mar	2 Hou	Ja al						
TO B	19a. INFORMANT'S NAME (Type/Print)	A 11 19b. N	AAILING ADDRESS (Street	et and Number or Rural i	Route Number, City or To	A						
-	200 METHOD OF DISPOSITION	, Hodullah 3	tob Wa	ashingto			o, md 21244					
	120 METNOD OF DISPOSITION 120 Burlel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from State 20b. PLACE AND centery, crema	tory of the place	Name of	DATE 200.	cation - city	or Town, Stata					
	21. SIGNATURE OF FUNERAL SERVICE LIC			AND ADDRESS OF FA	CILITY	w. a.	01310011110					
	* Hale 7	March	47	arch fi	14 book	0,01						
	23. PART i. Enter the diseases, or o	complications that coused the death	h. Do not enter the	mode of dying, suc	h as cerdiec or reap	piratory arreat,						
	IMMEDIATE CAUSE (Finel	List only ona couse on each ima.	0	F -1			interval Batween Onset and Death					
	disease or condition resulting in death) e. Due TO (OR AS A CONSEQUENCE OF):											
7		DOE TO (ON AS A CONSCOOL	ence or):									
Ō	Sequentielly list conditions, If any, leading to immediate	DUE TO (OR AS A CONSEQUE	ENCE OF):									
ICA	CAUSE (Disease or Injury	cDUE TO (OR AS A CONSEQUE	ENOT OF									
CERTIFICATION	that initiated events resulting in deeth) LAST	DOE TO (OR AS A CONSECUE	ENCE OF):									
	DARY II Other plantinest and diam	J.										
CAL	PART II. Other algorificent condition CHRONIC RENAL FAILU	-	ulting in the underly	ring causa givan in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE					
MEDIC	OIMONTO NEMAE TATEO	NL .			1 □ YES	2 NO	OF DEATH?					
7	DID TOBACCO USE CONTE	RIBUTE TO CAUSE OF DEATH	YES NO	UNCERTAIL	NZ		1 TYES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE (OF DEATN (Check only o									
YSI	1 X YES 2 □ NO	1 Inpatient 2 ER/Outpatient 3		ome 5 - Residence								
	27. MANNER OF DEATH 5 Pending	(Month, Day, Year)	INJURY	INJURY AT WORK? YES 2 XXO	28d. DESCRIBE NOW UNKNOWN	INJURY OCCURE	iD .					
) BY	Y Accident Investigation 3 Suicide G(Y) Could not be	28e. PLACE OF INJURY — At home				and Number or R	PLAR GROVE ST.					
COMPLETED	4 Homicide determined	building, atc. (Specify)	D AT HOME		BALTIMORE,		PLAR GROVE SI.					
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PNYSI	CIAN: To the best of my knowledge, dasth	occurred at the time, d	ete and place, end due	to the cause(s) and m	enner ea stated.						
ON ON	2 X MEDICAL EXAMINE	R: On the basis of examination and/or inv	eatigation, in my opinior	n, death occured at the	lime, date end place, a	and due to the ca	use(a) and manner es stated.					
BE 0	296 SICHATURE AND TITLE OF CERTIFIER	'L AM		29c. LICENSE NUI	MBER		GNED (Month, Day, Year)					
2	30. NAME AND ADDRESS OF PERSON WHI	O COMPLETED CAUSE OF DEATH (ITEM	(Type Print)	O.C.M	.E.	OCT	11, 1995					
	TLARON LOC	K= M) 111	L Penn St	reet, B	altimore	, Mary	land 21201					
	31. DATE FILED (Month, Day, Year)	32. NEGISTALA'S SIGNATURE	1									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			REGISTRAR	AND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.
•			The second secon	2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH OCTOBE F 1.2 1985 738 MM In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. WONTHS DAY'S HOURS MINN, (Mornh, Day, Year) OCTOBE F 1.2 1985 3. TIME OF DEATH OAY NOW HE DAY'S HOURS MINN, (Mornh, Day, Year) Country)
	, 2, 3 should	ЕСТОЯ	220-66-7051 1 M XX F 8: 9a. FACILITY NAME (If not institution, give street and number) North Arundel Ho; RESIDENCE OF DECEDENT	
	burial-transit permit. Pages 1,	B	MD Anne Arundel	10c. CITY, TOWN OR LOCATION Brooklyn Park 1 Ures 2 1 No
jan.	-transit pen	FUNERAL	10 STREET AND NUMBER P. O. BOX 2762 11. MARITAL STATUS 12. WAS DECEDENT EVER IN	101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? U.S.A.
21215-0020	as the burial	BY	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 YES, OIVE WAR OR DA	2 KINO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, atc.
	hed for use a	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker Own Home
MARYLAND retained by the hospit	5 should be detached for notifiled at once.	BE CON	17. FATHER'S NAME (First, Middle, Last) Unknown Schaffer	16. MOTHER'S NAME (First, Middle, Meiden Surname) UNKNOWN
E, MA		5	Louis C. Wood	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 4601 Ritchie Hgwy. Brooklyn Park MD 21225
ALTIMORI death. Page 6 may	director, p		1 A Burial 2 Cremation 3 Removal from State ceme	PLACE AND DATE OF DISPOSITION (Name of olary, crematory or other place) Altimore Natl. Cem. 10-16 Baltimore MD 22. NAME AND ADDRESS OF FACILITY
BALTIMORE, I	by the funeral director, page smoval. Ical examiner must be		· News E. Smith	Gary L. Kaufman Funeral Home of Elkridge Inc
The 24 hours	completely filled in by the ial, cremation, or remove a event, the medical		ahock, or heert fallure. List only one cause on ee IMMEDIATE CAUSE (Finsi	the deeth. Do not enter the mode of dying, such as cardlec of respiratory srrest, such line. Approximate Interval Between Onset and Death ON ASCULAL ACCIDENT CONSEQUENCE OF):
P.O. BOX 68760 th certificate be executed with	ending physician and con if Hygiene prior to burial, or other traumatic or	ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that lettled executions).	CONSEQUENCE OF: OIAL FNFANCTION CONSEQUENCE OF: FRS MELLITS Syears
RECORDS, P	en signed by the of Health and Me shows any injur	: MEDICAL CE	PART II. Other significent conditions contributing to deeth bu	PERFORMED? 1 YES 2 NO AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
TAL The law	State Dept State Dept Item 23	YSICIAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	28. PLACE OF DEATN (Check only one)
OF	this with	ву Рн	27. MANNER OF DEATN 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation 26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 18c. INJURY AT WORK? M 1 YES 2 NO 26d. DEŞCRIBE HOW INJURY OCCURED
DIVISION OR ATTENDING	DIRECTOR: hours after Item 28 I	PLETED	4 Nomicide determined building, stc. (Specification of the control	— At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 26ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
E HOSPITAL	FUNERAL within 72 TANT: #	E COMPL		and/or Investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)
THE	TO THE DE filed IMPOR	TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	M) D28221 October 12,1995
			31. DATE ELLED (MONTH, DEV MONT) 31. DATE ELLED (MONTH, DEV MONTH) 32. REGISTRAT'S SIGNA OC. 11. SALVERS 33. REGISTRAT'S SIGNA OC. 11. SALVERS 34. SALVERS 35. REGISTRAT'S SIGNA OC. 11. SALVERS 36. SALVERS 37. REGISTRAT'S SIGNA OC. 11. SALVERS 38. REGISTRAT'S SIGNA OC. 11. SALVERS	1 HOSPITAL DRIVE, GLEN BURNIE MARYCAND STURE ZIOGO



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	_	1 - FOR STATE OF REGISTRAR	MARYLAND / DEI CERT	PARTMENT OF H	EALTH AND MEI	NTAL HYGIENE REG. NO.	<u> </u>	
		1. DECEDENT'S NAME (First, Middle, Last) Pun Hing	WONG			DATE OF DEATH DAY CLOBER 1		3. TIME OF DEATH 9:10 P
P		4. SOCIAL SECURITY HUMBER 5. SEX 1 1 1 1 1 2 1 1 1	6. AGE (In yrs. lest birth	oley) IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN. SE	OATE OF BIRTH (Month, Day, Year)	1946 CF	HPLACE (State or Foreign http://
2, 3 should	TOR	90. FACILITY HAME (If not institution, give street and number) Franklin Square Hosp RESIDENCE OF DECEDENT	ital	Possvi	R LOCATION OF DEATH		Baltimo	
1. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Md. Baltimore	10c	Baltimor				10d. INSIDE CITY LIMITS? 1 □ YES 2 ☑ HO
n. ansit permit.	ERAL	6 Hallfield Court		101.	21236		U.S.A.	WHAT COUNTRY?
5-0020 nding physician. is the burlal-transit (BY FUN	1 Never Married 2 X Married FORCES?	EHT EVER IH U.S. ARMED 1 YES 2 HO E WAR OR DATES	If yes, spe	EHDENT OF HISPAHIC Ocity Cuban, Maxican, Pt 2 X NO Specify: (erio Rican, etc.)	Ble Spe	CE — American Indian, ck, White, atc. cc/ly: riental
2121 al or atte for use a	LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give kin- life. Do N	NT'S USUAL OCCUPATION d of work done during mos OT use retired.)	N t of working	16b. KIND OF BUS	IHESS/INDUSTRY	
YLAND 2 by the hospital be detached for	E COMPL	5th 17. FATHER'S HAME (First, Middle, Last) Yuk Wong	Che	f	18. MOTHER'S HAME (First, Middle, Maiden S	aurant	
MAR retained 5 should	TO B	19a. IMFORMANT'S NAME (Type/Print) Mary Lin		LING ADDRESS (Street and Hallfield				3. 21236
Age 6 may be director, page 9		20a METHOD OF OISPOSITION 1	20b. PLACE AHD D	ATEOFDISPOSITION (Name of or other place) S Of Fait	ne of	DATE 20c LOC	ATION — City or 1	Town, State
SAL II r death. F e funeral al. examin		FUNERAL SERVICE LICENSEE	5	Brad1∈ 2134 W	p ADORESS OF FACILITY EY-AShtor Villow SE	Funera Fring Ro	d.,Balt	21222 e, Inc. co.,Md.
withir 24 pletely fill cremation, the		23. PART i. Enter the diseases, or complications abook, Dr heart failure. List only one of IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due	het ceused the deeth. Seuse on each line. Pelasidia C TO (OR AS A CONSEQUENCE				atory arreat,	Approximate interval Betwee Onset and Deat
th certificate be executed physician and Hygiene prior to burn of other traumatic	ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	TO (OR AS A CONSEQUENC					
uires that the signed by the Health and M	JICAL	PART II. Other algnificant conditions contributing	to death but not resulti	ing in the underlying	ceuse given in Part	i. 244. WAS AN A PERFORM	MEO?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 22 NO
N: The law req ficate has been State Dept, of Item 23 sho	N N	DID TOBACCO USE CONTRIBUTE TO (25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		YES NO DEATH (Check only one)	UNCERTAIN 4	3		
NG PHYSICIAN: The ther this certificate bath with the State marked, or Item	≥	1 YES 2 NO 1 inpatient : 27. MAHNER OF DEATH 28a. DATE	OF INJURY 28b.	DA 4 Nursing Home TIME OF 1900 NURY WOR	IK?	Other (Specify) . DESCRIBE HOW IH.	JURY OCCURED	
TTENDI TTENDI TTOR: A after da	ED	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. PLAC	OF INJURY — At home, ta		ES 2 NO 261.	LOCATION (Street an City or Yown, State)	nd Number or Rural	Route Number,
AL OR AL DIRE	뒫	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of						(s) end manner as stated.
TO THE HOSPITAL TO THE FUNERAL TO TH	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	Systian		29c, LICENSE NUMBER	/	29d. DATE SIGNED ► (0/) 1	D (Month, Day, Year)
15		30. NAME AND ADDRESS OF PERSON WHO SOMPLETED TO M) LYAY L 31. PAPE FILED (Meeting PROYER) 32. RECORD	JYBVMC	11 14 .	EAMenn	Ake	BAUN	NA MZIZZ
	, 1	OUIT O 1333 AMM WIND	or the Walk					

FilmG, 728, item #1, 10/16/95,cyw, per f.h. 1 - STATE

STATE OF	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		PEDTIEICATE	0	E DEAT	FAA		

_	HEGISTHAN		CENTI	FICALE	OF DEA	1 11	RE	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH DAY	YEAR	3. TIME OF DEATH
	BERTHA	GREENWOOI						13 19		11:34 am +
	4. SOCIAL SECURITY NUMBER		(fin yrs. lest birthday		EAR IF UNDER	R 24 HRS.	7. DATE OF BI (Month, Day,		B. BIRT	HPLACE (State or Foreign stry)
	216-03-4950	1 M 2 F	91 YRS.				April 4.	1904	N	Maryland
œ	9a. FACILITY NAME (If not institution, give a				WN OR LOCATI			90.	COUNTY OF	
2	Saint Joseph Medic	cal Center		To	wson, I	Maryla	and		Baltim	ore
E C	10e. STATE 10b. COUNTY	,	10c. C	TY, TOWN DR L	OCATION		_			10d. INSIDE CITY LIMITS?
DIRECTOR	Maryland r	ı/a		Ba	altimor	re				1 X YES 2 NO
AL	10e. STREET AND NUMBER				10f. ZIP COD			101	. CITIZEN OF	WHAT COUNTRY?
FUNERAL	1524 Ralworth Roa	ıd				212	18		USI	A
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES		13. WAS	DECENDENT	OF HISPANI	C ORIGIN? (Sp., Puerto Rican,	ecify Yea or N	o- 14. RAC	CE — American Indian, ck, White, etc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR		1 🗆	YES 2 X NO	Specify:	, Pueno nican,	etc.)	Spe	cttv:
	15. DECEDENT'S EDUC	CATION	Tes DECEDENT	0.1101111 0.0011	2471011					White
	(Specify only highest grade Elementary/Secondary (0-12)	completed)	16a. DECEDENT (Give kind o life, Do NOT	s usual uccu work done durii use retired.)	PATION ng most of worki	ing	166. KIND	OF BUSINES	S/INDUSTRY	
2	12	College (1-4 or 5+)		omemak				At	Home	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					HER'S NAM	IE (First, Middle,			
BE C	William G. Greer	boowi						Cross	,	
B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	D ADDRESS (SI	reet and Number	r or Rural Ro	oute Number, Ch	ly or Town, Sta	te, Zip Code)	
2	Mr. Donald A. Wil	ey	1 Ove	r Park	Court	Ba	1timor	e, Mar	yland	21234
	20s. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remo		b. PLACE AND DAT		N (Name of		DATE	20c. LOCATIO	ON — City or T	own, State
	4 Donation 5 Other (Specify)	- 0	Parkwo	od Cem	etery	10/	16/95	Balt	imore	Maryland
- 1	21. SIGNATURE OF FUNERAL SERVICE LIG	ENSE		22. NA	E AND ADDRE					
	* Michael	Buch		Leon	ard J. R	Nuck. 1	Inc. 530	5 Harfo	rd Road	21214
- 1	23. PART I. Enter the disease, or o	omplications that cause	ed the death. Do							Approximate
	shock, or heart feliure. I	List only one cause on	each lina.		1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1	0.4.10.2			,	Interval Between Onset and Death
	disease or condition	CONGESTIV	E HEART	ALURE						3-6 YEARS
	reaulting in death)		A CONSEDUENCE							
z		ARTERIOSC	LEROTIC	CARDIO	VASCUL	AR DI	SEASE			YEARS
입	Sequentially list conditiona, if sny, leading to immediate	DUE TO (DR AS	A CONSEQUENCE	OF):						
2	CHOSE (Disease of Hilloth	2								
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEDUENCE	OF):						
5		1.								
EDICAL CERTIFICATION	PART II. Other significant conditions	contributing to death	but not resulting	In the under	lying csuse (given in P	Part I. 24a.	WAS AN AUTO		b. WERE AUTOPSY FINDINGS
Š	CHRONIC OBSTRUC	OTIVE LUNG D	SEASE					YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	HYPONATREMIA						_ ' _	TES SON		OF DEATH?
¥	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH Y	ES NC	□ UNC	ERTAIN	K			1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE							
Sic	1 TES 2 ND	HØSPITAL:	Ipatient 3 DOA	OTHER:	Home 5 🗆 Re	asidence 6	Other (Spec	clfy)		
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		ME DF 286	: INJURY AT WORK?		28d. DESCRIBE	HOW INJUR	Y OCCURED	
BY	Natural 5 Pending Accident Investigation			4.4	YES 2	ND				
- 10	3 Suicide 8 Could not be	28e. PLACE DF INJUR building, atc. (Sp	Y — At home, ferm	street, factory,	office		28f. LOCATION City or Town	(Street and No	umber or Rural	Route Number,
Ë I	4 Homicide determined								_	
립	29a. CERTIFIER 1. CERTIFYIND PHYSIC	CIAN: To the best of my kno	wiedge, death occu	red at the time,	date and place	, and due to	o the cause(a)	and manner a	e stated.	
COMPLETED	one) 2 MEDICAL EXAMINE	R: On the beels of examinati	on and/or investigat	lon, in my opini	on, death occur	red at the ti	lme, data and p	laca, and due	to the cause(a) and menner as stated.
шШ	296. SIGNATURE AND TITLE OF CERTIFIER	n 10 .			29c. LICE	ENSE NUMB	BER			D (Month, Day, Year)
TO B	Bealing ?	. Wingor	-, M.	0.	D16	492		•	Oct.	13.1995
F	30. NAME AND ADDRESS OF PERSON WHO				5-175 (Page					7
	BEATRIZ P. DIZON,M				N,MAR	YLAND	21204			
	OCT 16 199	32. REGISTRANTS SIG	ATURE-	L						
- 1	0017 0100	1		-						

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withm 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to bright and Married Minimum after to bright and Married Minimum after to bright and Married Married Committed or seminal.	be the within 12 hours alter death with the State Dept. Or regult and mental hybers prior to bound, commons, or convers. IMPORTANT: If them 28 is marked, or them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,
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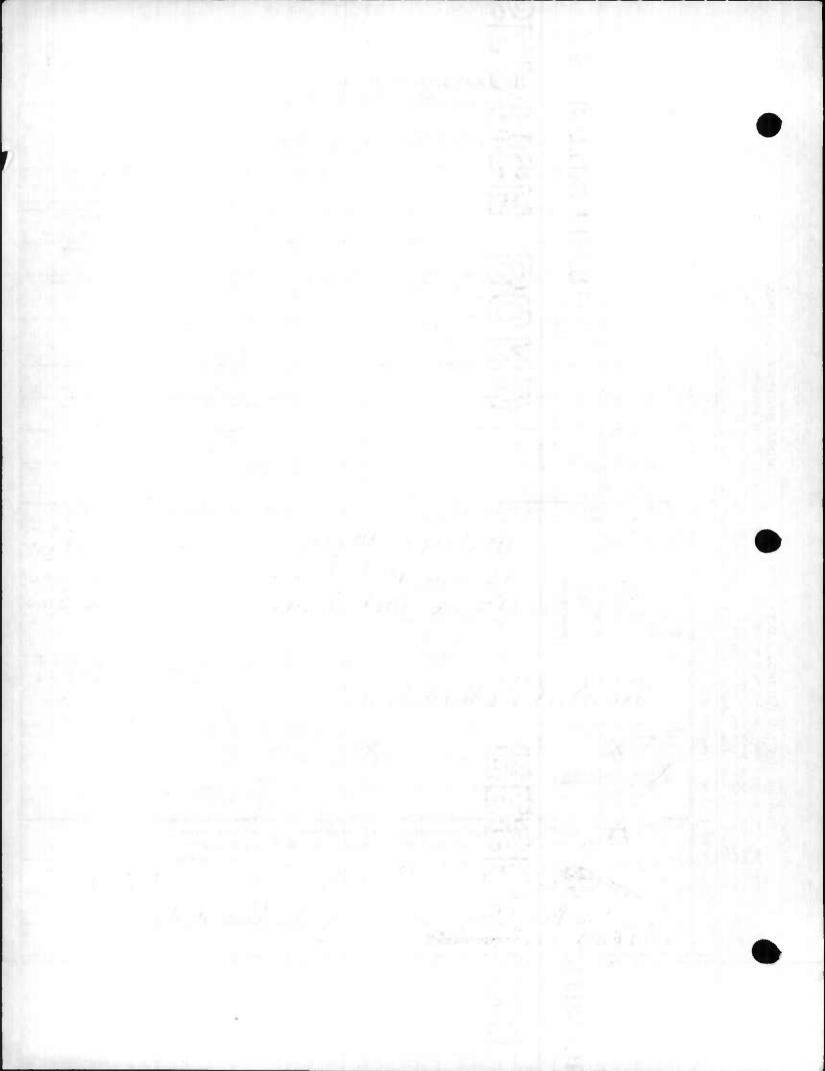
0.00								-	J	
1 - STATE REGISTRAR	STATE OF MA				IEALTH AND I DEATH	MENTAI	HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Las	*		MEDO			2. DATE	OF DEATH	Y	YEAR	B. TIME OF DEATH
IRVIN	К.			TER,	Jr.	DCTC			995	8:34 A
4. SOCIAL SECURITY NUMBER 218-42-4557	TXXM 2 □ F	AGE (In yrs. last bir	YRS. IF U	NDER 1 YEAR THE DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH	946	Country)	yland
90. FACILITY NAME (If not Institution, give 507 N. LUZERI			100000		MORE CI	EATH		9c. COU	NTY OF DEA	ATH
RESIDENCE OF DECEDENT									/ 11	
507 N. LUZERI RESIDENCE OF DECEDENT 10a. STATE 10b. COUN Md.	Baltim			timo						INSIDE CITY LIMITS? YES 2XXNO
100. STREET AND NUMBER 2419 Zion R	d.			10	2122	7			U.S.	A .
10. STREET AND NUMBER 2419 Zion Ro 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2 NO	D	if yes, sp	ENDENT OF HISPAN ecity Cuban, Maxica 22 NO Specifi	in, Puerto I		or No-	Black,	- American Indian, White, atc. White
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) 9 th 17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5+)	(Give I life. Do	kind of work o NOT use retir	/		16b	KIND OF BUS			
9th	N/A		Const	able					ore	City
17. FATHER'S NAME (First, Middle, Last) Irvin K. We	bster,Sr.				18. MOTHER'S NA Eliz	abet	h M.	Rul	ey	
19e. INFORMANT'S NAME (Type/Print) Mrs. Linda M.	Webster	19b. M 2	ALING ADD	ress (Street	nnd Number or Rural Rd. Bal	timo	ber, City or Town	n. Stete, Zi	227	
204. METHOD OF DISPOSITION 132 Burlei 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	20b. PLACE AND cemetery, cremate			th Cem.	1 O			City or Tow	
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Juliaci	1	22. NAME A	ND ADDRESS OF FA	CILETY	11. 2.		7.7.0	•
Herley	Maller			Har 752	nd Address of FA tley Mi 7 Harfo	ller rd F	Rd. Ba	eral	Hom , Md	e •
23. PART I. Enter the diseases, o ehock, pr haert failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Liet only ona ceuse	or AS A CONSEQUE	rchos		ode of dying, suc	h aa card	diac or reapi	ratory ar	rest,	Approximate Interval Between Onset and Daati
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	с.	PR AS A CONSEQUE								
CAUSE (Disease or injury that initieted events resulting in deeth) LAST	DUE TO (0									
that initieted events resulting in deeth) LAST	d.	eeth but not res		e underlylr	ig ceuse given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DART II. Oak on almoldings a smaller	d.		ulting in th			_	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
DART II. Oak on almolding at a smaller	Ions contributing to de	SE OF DEATH	uiting in th YES [OF DEATH (C	NO [UNCERTAI	_	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DART II. Oak on almoldings a smaller	Ions contributing to de	SE OF DEATH	Ulting in th	NO [UNCERTAI	N 🔀	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	Ions contributing to de	SE OF DEATH 26, PLACE (ER/Outpetlent 3 JURY 2	Ulting in th	NO [theck only one HER: Nursing Hot 28c. IN	UNCERTAI	N 🔀	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PART II. Other algorificent conditions of the property of the part	NTRIBUTE TO CAU HOSPITAL: 1 Inpetient 2 E 28e. DATE OF IN (Month, Dey.	SE OF DEATH 26. PLACE (ER/Outpetlent 3 1 JURY Year) 2	Ulting in th	NO [heck only one HER: Nursing Hot 28c. IN W	UNCERTAI	6 Other	PERFOR	NJURY OC	CCURED	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
PART II. Other algorificent conditions of the person of th	MTRIBUTE TO CAU HOSPITAL: 1 Inpatient 2 E 28e. DATE OF In (Month, Day, 26s. PLACE OF In be building, et	26. PLACE (ER/Outpetlent 3 JURY Year) INJURY — At home c. (Specify)	Ulting in th	NO Eneck only one HER: Nursing Hot 28c. IN M 1 1	UNCERTAL The State of the stat	N □ Other	PERFOR 1 PYES 2 W (Specify) SCRIBE HOW I ATION (Street or Town, State)	NJURY OC	CCURED or or Rural Ric	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY YES 2 NO
PART II. Other algorificent conditions of the property of the property of the property of the part of	NTRIBUTE TO CAU HOSPITAL: 1 Inpetient 2 E 28a. DATE OF IN (Month, Dey, be b	26. PLACE (ER/Outpetlent 3 JURY Year) INJURY — At home c. (Specify)	Ulting in th	NO Eneck only one HER: Nursing Hot 28c. IN M 1 1	UNCERTAI DESCRIPTION WAS Residence JURY AT YES 2 NO The send place, and due death occured at the 29c, LICENSE NU	6 Other 28d. DE:	PERFOR 1 PYES 2 W (Specify) SCRIBE HOW I ATION (Street or Town, State)	NJURY OC	occured or or Aural Ro sted. the cause(a)	AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! YES 2 NO Nutle Number, and manner as stated. Month, Day, Year)
PART II. Other algnificent conditions of the property of the p	NTRIBUTE TO CAU HOSPITAL: 1 Inpatient 2 Ea. DATE OF IN (Month, Day, 1 26a. PLACE OF In UNSICIAN: To the best of m	SE OF DEATH 26. PLACE (ER/Outpetlant 3 JURY Year) 21 INJURY — At home (c. (Specify) by knowledge, death hation and/or invention and/or invention and/or invention.	Ulting in the YES [OF DEATH (COO) DOA 4 COO) TIME OF INJURY In occurred at eatigation, in	NO [heck only one HER: Nursing Hot W W 1]	UNCERTAI DESTRUCTION DESTRUCT	6 Other 28d. DE:	PERFOR 1 Series 2 If (Specify) ACTION (Street or Yown, State) use(a) and mere a and place, ar	NJURY OC	occured or or Aural Accured. The cause(s)	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! YES 2 NO



1 -	FOR STATE REGISTRAR
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

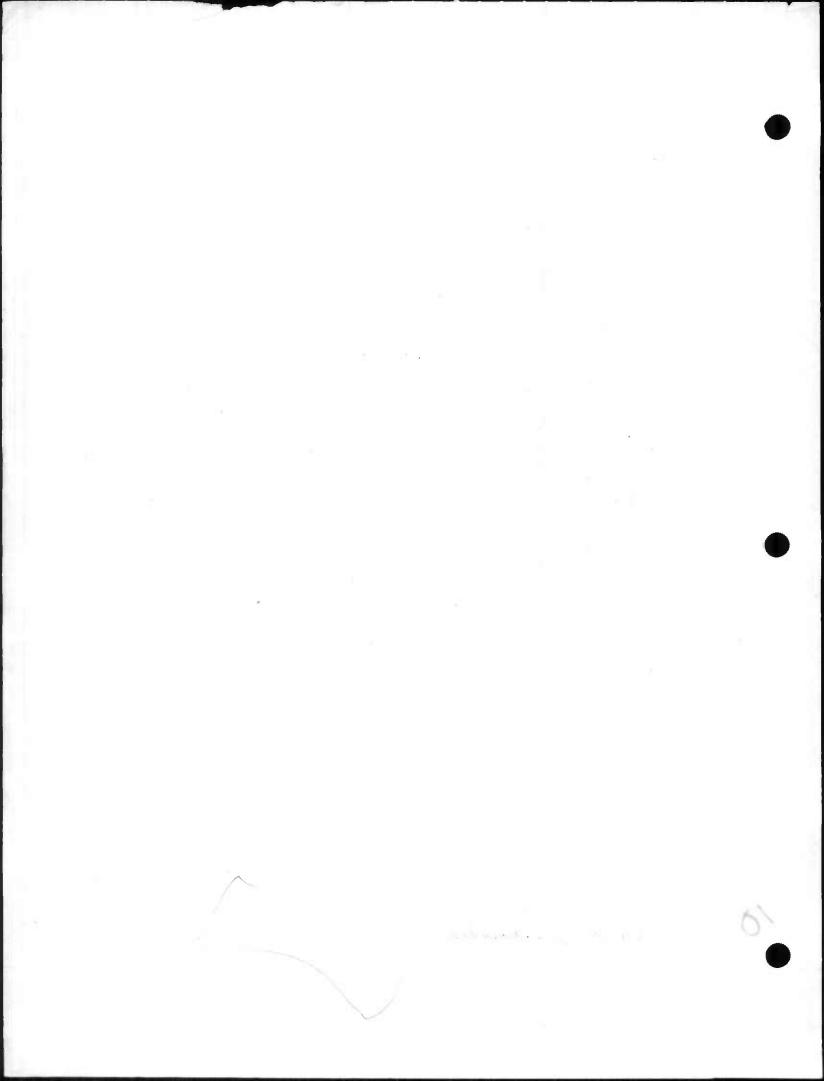
		HEGISTRAR		CERTIF	ICATE	P DEATH	REG. NO	J.	
		1. DECEDENT'S NAME (First, Middle, Less) DAVIL	JU	VILLS			2. DATE OF DEATH MONTH D	W/3 95	3. TIME OF DEATH
Pie		4. SOCIAL SECURITY NUMBER 218-62-4626	1 M 2 - F	E (In yrs. lest birthday) 42 YRS.	IF UNDER 1 YEA	B HOURS MM.	7. DATE OF BIRTH (Month, Day, York)	13 N	BIRTHPLACE (State or Foreign Country)
2. 3 should	TOR	96. FACILITY NAME (If not institution, give a Medbridge Nurs		r		n on Location of Di edale	EATH /	9c. COUNTY Bal	of DEATH Ltimore
t. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY Maryland Balt	imore		ry, town on Lo				10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
nsit permi	FUNERAL	100. STREET AND NUMBER 4634 Todd Poil	nt Lane			101. ZIP CODE 21219	3 71-81 E.	1000	USA
5-0020 nding physician. ss the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	If yes	DECENDENT OF NISPAI , specify Cuben, Mexics YES 2 NO Specifi			RACE — American Indian, Black, White, etc. Specify: White
2121	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)			USUAL OCCUP work done during se retired.)	most of working	State		rnment
MARYLAND : retained by the hospital 5 should be detached it notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) James B. Will:	5	02041	uonoc	18. MOTNER'S NA	ME (First, Middle, Melden	Sumeme)	
MAR retained 5 should notified	00	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	net and Number or Rural	Route Number, City or Tow	vn, State, Zip Coc	de)
	5	James B. Will:	S						Md. 21219
IMORE, Page 6 may be Il director, page		20e METHOD OF DISPOSITION 1 \(\tilde{\Omega}\) Burlal 2 \(\tilde{\Omega}\) Cremetton 3 \(\tilde{\Omega}\) Rem 4 \(\tilde{\Omega}\) Donetton 5 \(\tilde{\Omega}\) Other (Specify)		ob. PLACE AND DATE emetery, cremetory or confidens	of F	aith	10/15 B	altimo	
ALT death. e funera		21. SIGNATURE OF FUNERAL SERVICE LIC	olt Conn	elly	71	10 Solle	uneral Hers Point	Rd. 2	
with hours with the filed in b cremation, or rerestrent, the median		23. PART I. Enter the disease, or shock, or hear failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Mul	ed the death. Do each line	My	eloma	h as cardisc or reap	iratory arrest,	Approximate Interval Between Onset and Death
O. BOX 68760 entificate be executed with physician and complet giene prior to burial, create traumatte even	ERTIFICATION	Sequentially list conditions, if any, leading to immedista cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	130,	A CONSEQUENCE O	ietai	talin-			< 3 mo
e Hy	CERTI	resulting in death) LAST	d						
CORD; uires that the signed by the Health and M ws any inju	MEDICAL	PART II. Other significant condition Schizop Mentu	hrenia	but not resulting		ying cause given in	Part I. 24a. WAS AN PERFOR	RMED?	24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
OF VITAL RE PHYSICIAN: The law requ this certificate has been with the State Dept. of rked, or item 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	LI CONTINU			. PLACE OF DEATN (Ch	eck only one)		
CIAN: prtifical the Sta	YSIG	1 TYES 2 100	HOSPITAL: 1 Inpatient 2 ER/O			iome 5 Residence	8 Other (Specify)		
ON OF VITA DING PHYSICIAN: The After this certificate his death with the State D marked, or item	ву Рн	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJUR (Month, Day, Year) IN	JURY M 1	INJURY AT WORK? YES 2 NO	29d. DESCRIBE HOW		
TTEND TTEND TTEND TTEND TTEND TTEND	ETED	3 Suicide a Could not be determined	28e. PLACE OF INJU- building, atc. (S)	RY — At home, larm, pecify)	street, factory, (office	28f, LOCATION (Street City or Town, State)	end Number or R)	tural Route Number,
= 2 k E	COMPLET	one) 2 MEDICAL EXAMINE	CIAN: To the best of my kno						suse(e) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within	O BE	29b. SIGNATURE AND TITLE OF ANTI-LE	= Ziad	K-W!	1120/11	D4190		29d. DATE SI	GNED (Monito, Dey, Year)
12		30, NAME AND ADDRESS OF PERSON WH	orFlen	DEATH (ITEM 27) (Type	Print)	Ral	lamore.	mo	21204
		oct 16 1995	32 REGISTRAR'S S	NATURE		7,			



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DIVISION	

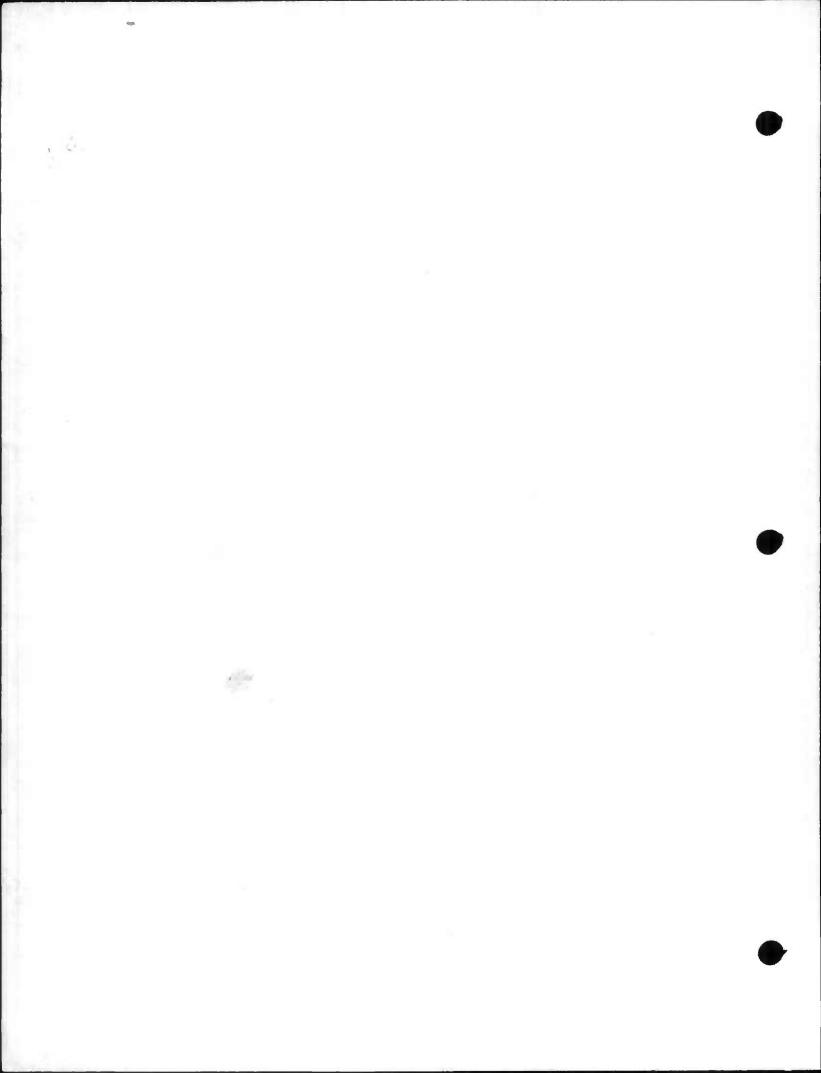
TO THE HOSPITAL OR ATTENDING PHYSICIA TO THE FUNERAL DIRECTOR: After this certibe filed within 72 hours after death with the IMPORTANT: If Item 28 Is marked, or

FOR 1 - STATE REGISTRAR	STATE OF MARYL	LAND / DEPARTI			MENTAL	HYGIENE REG. NO.				
1. OECEDENT'S NAME (First, Middle,					2. DATE OF DEATH 3. TIME C					
NANCY F	WINKL	ER			OCLA	ber 10	YEAR 95	15, 35	PM	
4. SOCIAL SECURITY NUMBER 217-50-0342	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BI								ign	
RESIDENCE OF DECEDEN 10a. STATE Maryland Ba	OUNTY altimore City	10c. CITY,	TOWN OR LOCAT	ION			104. INSIDE CITY LIMITS?	10		
			101	. ZIP COOE		10g. C	ITIZEN OF	WHAT COUNTRY?		
416 W. 23rd	Street			21211			USA			
10e. STREET AND NUMBER 416 W. 23rd 11. MARITAL STATUS 1 Never Married 2X Merried 3 Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 YES	2X NO	If yes, sp	ENDENT OF HISPAN acity Cuban, Maxica 2 NO Specify	in, Puerto Rk	(Specify Yaa or No- can, etc.)	- 14. RAC Blac Spec	E — American Indian ik, Whita, etc. iffy: White	i,	
15. DECEDENT'S		16a. DECEDENT'S US	SUAL OCCUPATION OF COMPANY	ON et of working	16b. F	IND OF BUSINESS/	NOUSTRY			
15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, La	College (1-4 or 5+)	ille. Do NOT use i	retired.)	st or working		Legal				
17. FATHER'S NAME (First, Middle, La				18. MOTHER'S NA		ddle, Maiden Sumame	,			
Edward (Gunther				Nelli	le Mockar	rd			
O I ISE. INT ONIMANT S NAME (1) POP TIME						r, City or Town, State,		04000		
Raryii U. Dicz	- Volument				-	sville,		21228		
20a. METHOD OF DISPOSITION 1 Duriel 2 X Cremetion 3 D	Removal from State Co	b. PLACE AND DATE OF melecy, crematory or other HIII top Se	DISPOSITION (No or place)	me of	DATE	20c. LOCATION				
4 Donation 5 1 Other Condy		TITICOP SE		ID ADDRESS OF FA	10/11	Towsc	on, Ma	aryland		
· Nalto	2 C/ Stella		Burg	gee-Henss	s Fune	eral Home Baltimor				
23. PARTI /. Enter the diseases	s, or complications that cause flure. List only one cause on o	ed the death. Do not	t enter the mo	de of dying, suc	h ss cardie	c or respiratory	srrest,	Approximat		
IMMEDIATE CAUSE (Final		. ^						Onset and		
disease or condition reaulting in dasth)		Factur	e					iLm	m	
	200	A CONSEQUENCE OF):	\					1 ×		
Sequentially list conditions,	b. ALC	A CONSEQUENCE OF:	abu) e				1014	int	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	Seb							17 day	u.c	
CAUSE (Disease or Injury that initiated events		A CONSEQUENCE OF):						1 000	7	
resulting in death) LAST	. Renal	L fair	Mrs.					6 H	S	
	ditions contribution to doubt		Abo wastatula		0.41					
<	Mattons contributing to death	Dut not rasuming in	tha underlyin	g cause givan in		PERFORMED?	SY 241	AWAILABLE PRIOR TO COMPLETION OF CA OF DEATH?	O	
₩				4				1 TES 2 N	0	
DID TOBACCO USE CO	ONTRIBUTE TO CAUSE (UNCERTAIL	иПТ					
25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:	28. PLACE OF DEATH	OTHER:							
1 YES 2 HO 27. MANNER OF DEATH	Inpetlant 2 ER/Out				8 Other					
		28b. TIME INJUI	RY WO	URY AT PRK?	28d. DESC	RISE HOW INJURY	OCCUREO			
2 Accident Investig 3 Sulcida 8 Could in 4 Homicide determin	28a. PLACE OF INJUR	RY — At home, farm, atreedity)	Al home, farm, atreet, factory, offica 281. LOCATION (Street and Number or Bural Route Number, City or Town, State)							
290. CERTIFIER							_		_	
(Check only	PHYSICIAN: To the best of my know (AMINER: On the beels of examination							(a) and manner or other	at a d	
8		on end/or investigation,	in my opinion, c						ned.	
29b. SIGNATURE AND TITLE OF CEI	. Mithans)		AT24	138°	146 1	octol	Den 10/	95	
E mad A.	MILE LOUISE OF D	CATH (ITEM 27) (Typo, P		wrial	No	ep. B.	et.	MD ZA	119	
31. DATE FILER (Mgth. 1995)	Jale 3 REGISTRAR'S G	NATURE								



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	-	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AND I	MENTAL HYGIEN			
		1. DECEOENT'S NAME (First, Middle, Last)	Zimmer	man			2. DATE OF OEATH	2 199	3. TIME OF DEATH	
9		010 00 04	SEX 6. AGE (In 89	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 0 6 22		BIRTHPLACE (State or Foreign Country) MD	
. 2, 3 should	CTOR	99. FACILITY NAME (If not institution, give street GOTONS VILLE RESIDENCE OF DECEDENT	nounity A	LUSING		OR LOCATION OF DE	EATH	9c. COUNTY Ba]	of DEATH timore	
oit. Pages 1,	OIR	10e. STATE 10b. COUNTY MD	VIA		y, TOWN OR LOC				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
an. ransit permit.	NERAL	1213 Light St.				01. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
-0020 Jing physician. the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	P. WAS DECEDENT EVER IN I FORCES? 1 TYPES IF YES, GIVE WAR OR DAT	2XXNO	If yes, s	CENDENT OF HISPAN specify Cuban, Mexica S 2 X NO Specify			RACE — American Indian, Black, White, etc. Specify: White	
21215-0 tal or attending for use as the	LETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondery (0-12)	ie. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTF					RY		
y the hospital be detached to	. 🗸	5th N/A Ho 17. FATHER'S NAME (First, Middle, Last)			omemaker/Seamstress Own Home 18. MOTHER'S NAME (First, Middle, Meiden Surname)					
ined hould		UNKNOWN 19a. INFORMANT'S NAME (Type/Print)	- <u>·</u>	19b. MAILING	ADDRESS (Street	end Number or Rural I	Inknown Poute Number, City or Tox	vn, State, Zip Cod	(9)	
ay be reta page 5 si	5	Margaret L. Moore					Baltimore			
E y T		20e. METHOD OF DISPOSITION 1 V Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State cemet	PLACE AND DATE OF Pery, crematory or of ltimore	ther place)			OCATION — City		
ALTIM death. Page funeral dir		21. SIGNATURE OF FLINERAL SERVICE LICEM	A A	7	Gary	Cem. AND ADORESS OF FAI L. Kaufma	n Funeral	Home o	f Elkridge Inc	
within 14 hours at appletely filled in by cremation, or removed.		23. PART I. Enter tha diseases, or comshock, Dr heert fellure. Lief iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Congesti	the deeth. Do not line.	bailt	faike	re		Approximete Interval Between Onset and Desth	
S, P.O. BOX 687.0 death certificate be executed attending physician and con ental Hygiene prior to burial. No or other traumatic et	ERTIFIC	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	DUE TO (OR AS A C			9,90	disea	sease year		
0 2 Z 3		PART II. Other significent conditions of	ontributing to deeth but	t not resulting i	n the underlyin	ng ceuee given in			24b. WERE AUTOPSY FINDINGS	
a a a a	EDIC	- Senile	Demo	ntia			1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
The Deer of St. of St. of	Σ	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S I NO	UNCERTAIN			1 TYES 2 NO	
E 22 E			OSPITAL:	B. PLACE OF DEAT	H (Check only one OTHER:)				
rSICIAN; The scate the the State		27. MANNER OF DEATH	Inpetient 2 ER/Outpet	28b. TIMI	E OF 28c. IN	me 5 Residence	8 Other (Specify) 28d. OESCRIBE HOW I	NJURY OCCURE	0	
OING PHYS After this of death with	ВУ Б	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 🗆	ORK? YES 2 NO				
TTENOI TTOR: A after d	8	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY — building, atc. (Specify	- At home, ferm, s	trast, fectory, offi	ce	261. LOCATION (Street (City or Town, State)	end Number or Ri	ural Route Number,	
OR DIRI	IPLET	29a. CERTIFIER (Check only	: To the best of my knowled	ige, death occurre	d at the time, dat	e end place, and due	to the cause(e) end mer	nner ee stated.		
HOSPITAL FUNERAL within 72 h	COMPL	2 MEDICAL EXAMINER: 0	n the baels of examination e	and/or Investigation	n, in my opinion,	death occured at the	time, date end place, an	nd due to the cau	use(e) and manner as stated.	
TO THE HOSPIT TO THE FUNERA DE filed within 7	O BE	111/4/00/ 7	acem my			D 159	18ER	29d. DATE SIG	NED (Month, Day, Year) 12/95	
		AMBTUH H	MAREN	50) L	201phi	n Stres	of Bols	Gimore	MD 2127	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCE 10, 1995 YEAR 8:00A Leonard Abrams 4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Dec. 28, 1905 578-09-9340 1)XXM 2 □ F 89 YRS Balt Md 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH Rc. COUNTY OF DEATH permit. Pages 1, 2, 3 : DIRECTOR Montgomery Arcola Nursing Home Wheaton RESIDENCE OF DECEDENT 10h COUNT the, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Wheaton 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 901 Arcola Avenue 20904 U.S.A. use as the burial-transit retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 MNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify: White 3 ₩ Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only H funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Printer Washington Post once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Isaac Abrams Gertrude Unavailable BE notified 19a. INFORMANT'S NAME (Type/Print) 196 MAILING ADDRESS (Street and Number or Flyral Figure Number, Citylog Town State, Zip Code) 2 Jean A. Stern Silver Spring, Md 20906 hours after death. Page 6 may be e e 20e. METHOD OF DISPOSITION

1 X Burlal 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Cing David Mem. Gdn.10-12 Falls Church, Va. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY Funeral Homes THOO Falls Church, Va. 22046 attending physician and completely filled in by the mal Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line Interval Retwo IMMEDIATE CAUSE (Final Onset and Death within 24 disease or condition resulting in death) ASPIRATION PURUMON, A RECURLANT
DUE TO (OR AS A CONSEQUENCE OF): event. new ref executed YRS traumatic PAHLINSONS DISHBL CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 n signed by the attent Health and Mental H Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. the MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY that shows any 1 TES 2 100 1 YES 2 XNO 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO L UNCERTAIN PHYSICIAN: Dept 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate HOSPITAL: OTHER:

Nursing Home 5 - Residence 8 - Other (Specify) 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 0 the 27. MANNER OF DEATH 28c. INJURY AT WORK? this c marked, 28a. DATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCUPED 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY After Investigation ATTENDING DIRECTOR: Af hours after de Item 28 Is r 3 Sulcide 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 9 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 29 SIGNATURE AND TITLE OF CERT BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Meste Daa 10/10/95 2 30. NAME AND ADDRESS OF PERSON W PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AAGUT AVE MARTIN C 31. DATE FILED (Month, Day, Year) OCT 1 7 1995 32. REGISTRAN'S SIGNATURE

permit. Pages 1, 2, 3 should

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notified

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BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS.

must examiner medicai 0 the cremation, traumatic event, prior to other 0 been signed by th pt. of Health and N shows any has be. Dept. c this certificate h with the State C irked, or item marked, THE FUNERAL DIRECTOR; After I filed within 72 hours after death 28 is r

IMPORTANT: If Item

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31. DATE FILED (M

OCT 1 7 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

owler

3. REGISTRAR'S SIGNATURE

ITEM: 20b, PER F.H. FILM G-728 10/17/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCT. 13, 1995 2:30 P. M LOUISE BURRELL 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day Year) 5 SEY 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS 1935 60 HOURA WASHINGTON, DC 230-44-2070 1 M 2 X F 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a DIRECTOR 1408 GOUGH ST. BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 10a. STATE MARYLAND BALTIMORE n/a X YES 2 NO 101. ZIP CODE 21202 FUNERAL 10e. STREET AND NUMBER STREET 1405 GOUGH 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2/VINO If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 X Never Married 2 Married Specify: BY 3 Widowed 4 Divorced BLACK 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) LONDON FOG SEAMSTRESS 12 th 18. MOTHER'S NAME (First, Middle, Maiden Surnam E - NINTE BRANHAM 17. FATHER'S NAME (First, Middle, Last) burrell oliver BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Rouse Number, City or Town, State, Zie Code)
2533 E. BIDDLE STREET, BALTIMORE, 9 21213 DAVIS ROSE Ε. 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 10/19 DATE Burial 2 Cremation 3 Ramoval from Stata DUNDALK, MARYLAND Donation 5 - Other (Specify) MEMOR I AL GARDENS 10-18 21. SIGNATURE OF FUNDILAR SERVICE LICENSEE WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Enter the diseases, or complications that could the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line. Approximeta interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition DUE TO (OR AS A CONSEQUENCE OF): lardiovascular disease resulting in deeth) CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in deeth) LAST PART II. Other algnificant conditione contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? t YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 | Nursing Home XIXRasidence 6 | Other (Specify) HOSPITAL: TXXYES 2 □ NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 29s. CERTIFIER (Check only 1 🗆 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and manner as atsted. 2 💢 MEDICAL EXAMINER: On the basis of azyminytion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND THILE OF CERTIFIER 29c. LICENSE NUMBER 29d DATE SIGNED (Month Day Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rav 1/89

OCT. 14, 1995

31. DATE FILED (Month, Day, Year)
OCT1 71995

32. RECISTRAR'S SIGNATURE

		ITEM: 1. PER F.H. FILM FOR 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	g-728 10/17 STATE OF M	ARYLAND /			HEALTH AND I		REG. NO			3. TIME OF DEATH
		Marie HE	LEN	Ви	usinsk	y		10	TH C	6	95	12:40pm
Pin	ECTOR	4. SOCIAL SECURITY NUMBER 220-14-2259	1 □ M 2 🂢 F	5. AGE (In yrs. las	YRS.	IF UNDER 1 YEAR	HOURS MIN.	Feb	of Birth th, Day, Year) . 27,1		s. BIRTH Country Ma	PLACE (State or Foreign y) ryland
1, 2, 3 should		Stella Maris RESIDENCE OF DECEDENT				96. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH Baltimore		
permit. Pages	AL DIRE	Maryland B.	altimore		10c. CITY, TOWN OR LOCATION Baldwin 10f. ZIP CODE			1				10d. INSIDE CITY LIMITS? 1 YES 2 NO
ISI	FUNERA	4814 Carroll M	anor Road				21013			U.S.A.		
ND 21215-0020 hospital or attending physician. ached for use as the burial-transit ce.	BY	t1. MARITAL STATUS t Never Merried 2 Merried 3 M Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 X	MED NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y It yes, specify Cuber, Mexican, Puerto Ricen, etc.) 1 YES 2 X NO Specify:					14. RACE Black Specif	- American Indian, t, White, etc.
r attend use as	ETED	15. DECEDENT'S EDU (Specify only highest grad	CATION completed)	(G	ive kind of wo	SUAL OCCUPA rk done during i	TION most of working	16	b. KIND OF BU	SINESS/IN	DUSTRY	
ND 2 hospital of ached for	PLE	Elementary/Secondery (0-12) 12th grade	College (t-4 or 5+)	me.	Home	maker			Own	Home	2	
g det Be	COMPL	17. FATHER'S NAME (First, Middle, Last)			-		18. MOTHER'S NAI			Sumame)		
retained by the S should be a	BE	Anton J. Matejovic 190. INFORMANT'S NAME (Type/Print) 190. MAILING					Helen					
(I) (I)	욘	Money I have a Track of the state of the sta							1013			
ALLIMORE, a death. Page 6 may be funeral director, page.		20p. METHOD OF DISPOSITION 12 Buriel 2 Cremetion 3 Ren 4 Denetion 5 Other (Specify)	noval trom State	20b. PLACE A	AND DATE OF metory or othe John S	disposition (or place) Cemet	Name of Cery	10		ydes,		yland
. 0		21. SIGNATURE OF FUNERAL SERVICE LI	censee dark i	A		Schi	AND ADDRESS OF FAC Imunek Fun Belair R	era				21236
22 miles		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, ahock, or heart failure. List only one cause on each line. Approximation.									Approximata interval Betwee Onset and Dea	
th certificate be executed by the certificate by th	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Pneumonia Due to (or as a consequence of): Due to (or as a consequence of):										
The reconding of the feath The law requires that the death te has been signed by the attenv are Dept. of Health and Mental H em 23 shows any injury, or	MEDICAL C	PART II. Other algnificant condition						_	24a. WAS AN PERFO t YES	RMED?		WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
has be bept.	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU			(Check only on		1 🗆				
	rsic	EXAMINER? 1 YES 2 NO	HOSPITAL:			THER:	ome 5 - Residence (8 🗆 Oth	er (Specify)			
F F F F F	ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	Month, Day	'Miner's	28b. TIME (M 1	NJURY AT VORK? YES 2 NO	28d. DE	SCRIBE HOW	INJURY OC	CURED	
OR ATTENOING DIRECTOR: After hours after death item 28 is mail		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, et	INJURY — At hou c. (Specify)	me, ferm, atro	et, tactory, off	lice	28f. LOC City	CATION (Street or Town, State)	end Numbe)	r or Rural R	pute Number,
로 정전 =	COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI					ite end piece, end due to death occured at the t					end menner es stated.
물 물 등 등	BEC	29b. SIGNATURE AND TITLE OF CERTIFIE	R				29c, EICENSE NUM	BER 4		29d. DA1	E SIGNED	(Month, Day, Year)
2 2 3 3	5	30. NAME AND ABORESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITEN	# 27) (Type. Pr	rint)	1, 7,	/		,		
15		Eddie Nakhuda					alley Ro	ad,	Tows	son,	MD	21204

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

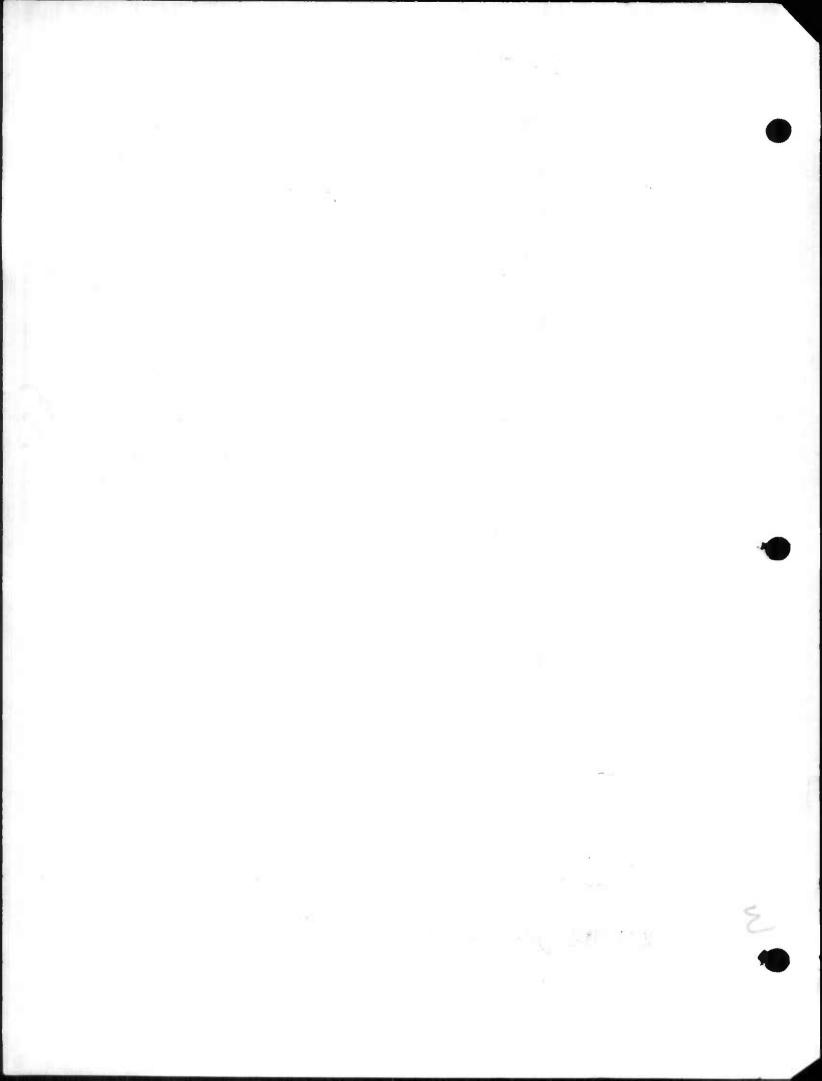
DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEM: 1. PER F.H. FILM G-728 10/17/95 t.t ITEMS: 23 PART I, 27, PER MEO FILM G-730 12/13/95 t.t

REGISTRAR DECEDENT'S NAME (First, RETHANY SOCIAL SECURITY NUMB 217-43-3348				CERTIF	ICAT	FOF	DEAT	TH		REG. NO.			
I. SOCIAL SECURITY NUMB	Middle, Last)			OLITTI	IOAI		DEA		2. DATE	OF DEATH			3. TIME OF DEATN
I. SOCIAL SECURITY NUMB		L.		BVE	RLEY				MONTH	BER I		YEAR	5:12 A
217-43-3348	ER	5. SEX	6. AGE (In y	rs. last birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH	7	8. BIRTI	IPLACE (State or Foreign
	3	1 M 2 T F	8 Mon	ths YRS.	MONTHS	DAYS	HOURS	MIN.	Fob.	2, 19	005	M a v	yland
e. FACILITY NAME (If not in:		reet end number)	0 1101	CIIO	9b, CIT	Y, TOWN O	R LOCATI	ON OF DE		4, 1.		NTY OF D	
JOHNS HOPE			L			BALT							
RESIDENCE OF DEC									_			N/A	
Oe. STATE	10b. COUNTY			10c. CIT	ry, town	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
Maryland		N/A			Ва	ltim	ore						1 X YES 2 □ NO
0e. STREET AND NUMBER						101.	ZIP CODI	E			10g, CIT	IZEN OF 1	WHAT COUNTRY?
3118 Brenda	an Ave	nue					212	13				U.	S. A.
1. MARITAL STATUS		12. WAS DECEDEN			13					i? (Specify Yes	or No-	14. RAC	E — American Indian,
Never Married 2		FORCES? 1				1 YES				Rican, etc.)		Spec	k, White, etc.
B Widowed 4 Divo	roed									,			White
	EDENT'S EDUC highest grade		16	Give kind of	work done	during mo	N st of workin	10	16b	. KIND OF BUS	SINESS/INC	DUSTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5	+)	life. Do NOT u									
N/A				Depen	dent					N/	A		
7. FATHER'S NAME (First, MI										Middle, Malden			
David Wayne		ey Sr.								Przyby			
9e. INFORMANT'S NAME (7)	1.3			10000						ber, City or Tow			
Michele L. 1		(Mother)	3118	Bren	ndan	Ave.	, Ba	ltim	ore, M	d. 2	1213	
loe. METHOD OF DISPOSITI		oval from State		ACE AND DATE			me of		DAT	E 20c. LO	CATION —	City or To	own, State
Donation 5 🗆 Other	(Specify) _		2 Ga	rdens	of F	aith		10/	13/95	5 Ba	1timo	ore,	Maryland
T. SIGNATURE OF EMPERA	L SERVICE LIC	ENSEE			22	NAME AN				1 11			
× / /	1	1								1 Home		~ Md	. 21213
IMMEDIATE CAUSE (Fird disease or condition resulting in death)	⇒			MYOPATHY DNSEOUENCE C				-		V I			Onset and Deal
Sequentially list conditi if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in deeth) LAS	diate ING Iry	c		ONSEQUENCE C									
PART II. Other significa	nt condition	s contributing to	deeth but	not reaulting	In the u	ınderiying	g ceuse	given in	Part I.	24s. WAS AN PERFOR	RMED?	248	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\square\) NO
DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF	DEATH Y	ES 🗆	NO 🛭	UNC	CERTAI	N 🗆				
25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL	HOSPITAL:	26.	PLACE OF DE	-								
CX YES 2 NO		1 Inpetient 2	ER/Outpatk	ent 3 🗆 DOA	OTHE	ER: uraing Hom	e 5 □ R	esidence	6 Othe	er (Specify)			
7. MANNER OF DEATH		28a. DATE Of	F INJURY Day, Your)	26b. TH	ME OF	28c. INJ	URY AT		28d. DE	SCRIBE NOW	NJURY OC	CURED	
	Pending Investigation	(MOM),	July, roury	- "	M		YES 2	NO					
	Could not be	26e. PLACE	OF INJURY -	At home, farm,	street, le	ctory, offic	•			CATION (Street		r or Aural	Route Number,
2 Accident	determined	Sunging	, atc. (Specify)						City	or Town, State)			
2 Accident 3 Suicide 6		ICIAN: To the best o											(s) and menner es stated.
2 Accident 3 Suicide 6 Momicide 4 Nomicide 9a. CERTIFIER (Check only 1 CERTIFIER)			A LINE AND LAND AND ADDRESS OF THE PARTY OF										
2 Accident 3 Suicide 4 Nomicide 29a. CERTIFIER (Check only one) 25C MED	ICAL EXAMINE	R: On the basis of	I AMITIMO (POTI M				00	CALOR AND	AADEC.				
2 Accident 3 Suicide 4 Nomicide 29a. CERTIFIER (Check only one) 25C MED		R: On the basis of	ixenimetron a					ENSE NU					D (Month, Day, Year)
2 Accident 3 Suicide 4 Nomicide 29a. CERTIFIER (Check only one) 25 MED 29b. SIGNATURE ND TITLE	OF CERTIFIE	R: On the basis of a							m.e	•			ER 13, 199
2 Accident 3 Suicide 4 Nomicide 29a. CERTIFIER (Check only one) 25C MED	OF CERTIFIE	R: On the basis of a	ISE OF DEATI	N (ITEM 27) (Typ			C	.c.	m.e		▶ OC	TOB	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

ONMH-16 Rev 1/89



3. TIME OF OEATH

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEOENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL I	
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1995 Geraldine Rose Bowen October 14 7:30A 7. DATE OF BIRTH (Month, Day, Year) April 12,1928 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTNPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER DAYS 213-28-5889 67 1 M 2 XF Maruland use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (# not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3339 Wallford Drive DIRECTOR Dundalk Baltimore RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Dundalk 1 YES 2 XNO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3339 Wallford Drive United States 21222 ay be retained by the hospital or attending physician, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, aic. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2X NO Specify: 1 Never Married 2 X Merried IF YES, DIVE WAR OR DATES Specify. BY 3 Widowed 4 Divorced White ETED 15. OECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Housewife 11 Years Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Orazio Massoni 70 Adeline Umano notified 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 William V. Bowen 3339 Wallford Drive Dundalk, Maryland 24 hours after death. Page 6 may be pe 20a, METNOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Sacred Ht. 08 Mary Cem. 10/17/95 Baltimore. Maryland 4 Donallon 5 Other (Specify) examiner NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. MD 21222 removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line. intervai Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition Mespirodory to tailure completely event. reaulting in death) burial. Advanced traumatic CERTIFICATION and Sequentially list conditions, prior to If any, leading to immediate ceuse. Enter UNDERLYING other t CAUSE (Diseese Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa been signed by the attending it. of Health and Mental Hygie resulting in deeth) LAST 0 Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL shows any COMPLETION OF CAUSE 1 YES 2 KNO OF DEATN? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ■ NO □ UNCERTAIN □ PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER:
4 □ Nursing Home 5 KRasidenca 6 □ Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this ce marked. 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY Investigation 26a. PLACE OF INJURY — At home, farm, streel, lactory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 29a. CERTIFIER
(Check only one)

One)

MEDICAL EVAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurad at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II BE 015546 ON NO COMPLETED CAUSE OF DEATH (ITEM, 27) Prope, Print) Local Kavan 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

for use as the burlaf-transit permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 6876	0
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FOR STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR MARGARET JANE BARRICK 1995 5:06 A. М October 14 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 138-038764 1 M 2 F 83 March 15, 1912 Pennsylvania Ba. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Cromwell Nursing Center Baltimore Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 YES 2 KHO 10e. STREET AND NUMBER 18g. CITIZEN OF WHAT COUNTRY? FUNERAL 101, ZIP CODE 914 Southerly Road 21204 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, etc. FORCES? 1 YES 2 XNO If yea, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: Specify BY 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16h. KIND OF BUSINESS/INDUSTRY (Give kind of work done during ite. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Motor Vehicle Administration once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 10 Samuel H. Crowl Ellen Jenkins BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mr. Charles B. Barrick 1034 Saxonhill Drive Cockeysville, Maryland 21030 pe 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 🔀 Burial 2 □ Cremation 3 □ Removal from State must 4 Donation 5 Other (Specify) Lake View Memorial 10/17/95 Eldersburg Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Wallace Ruck Towson Funeral Home, Inc. 1050 York Rd medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one ceuse interval Batween Onset and Death IMMEDIATE CAUSE (Final the disesse or condition event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, If any, isading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other that initiated events reaulting in death) LAST 0 Injury, PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 7-NO OF DEATH? Shows 1 TES 2 PNQ DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A PHYSICIAN: 23 28. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 0 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) Natural 2 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death with them 28 is mark BY Investigation Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide e FUNERAL Dis. 29a. CERTIFIER

(Chack and)

(CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On Willbeals of examplestion and/or invest death occured at the time, date and place, and due to the cause(a) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 16 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1) Ayman Akkad, M.D. 7000 Osler Drive Towson, Maryland 21204 31. OATE FILEO (Month, Day, Year) OCT 1 7 1995 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	YEAR	OF DEATH	
	Margaret Brow	5. SEX 6. AGE ((in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (
	175-05-8270		7 YRS.	MONTHS DAYS	HOURS MIN.	11-14-	1/	Country) PA	1	
CTOR	99. FACILITY NAME (If not institution, give street and number) 99. COUNTY OF DEATH Union Memorial Hosp Balto City N/A									
DIRECT	10a. STATE 10b. COUNT	Y	10c. CITY	, TOWN OR LOCA				10d. IN	ŞIDE CITY	
	MD 100. STREET AND NUMBER	Baltimore		Rosedale				1 🗆 Y	ES 2 Th	NO
FUNERAL	8347 Analee A	7e.		N N	21237		10g. CITIZEN OF WHAT COUNTRY? USA			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2 X NO ATES						n,		
TED	15. DECEDENT'S EDU (Specify only highest grade	16a. DECEDENT'S (Give kind of w life. Do NOT us	NT'S USUAL OCCUPATION d of work done during most of working							
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)				le Clerk Clothing Manu				
	17. FATHER'S NAME (First, Middle, Last) Michael Toth			16. MOTHER'S NAME (First, Middle, Meiden Surneme) Mary Lutz						
TO BE	190. INFORMANT'S NAME (Type/Print) Marjorie Moscat	and Number or Rural	Aoute Number, City or 1	own, State, Zip C	ode) 1237					
	20s. METHOD OF DISPOSITION 1X Burtle 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 0ak Lawn 10-18-95 Baltimore, MD									
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		Oak La	22. NAME A	ND ADDRESS OF FA			ore, MD		
	Cvach/Rosedale Funeral Home 1211 Chesaco Ave.									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory srrest, ahock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finsi disease or condition and provided in the cause of the cause of condition and provided in the cause of th									tween Dssth
	disease or condition a. CARDIOGENIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. DE MY OCARDIAL INFARCTION 24 HR									
CATION	Sequentially list conditions, If any, leading to immediate MYOCARDIAL INFARCTION 24 HR									
FICA	CAUSE (Disease or injury	cDUE TO (OR AS A CONSEQUENCE OF):								
ERTIFIC	thet initiated events resulting in death) LAST d									
AL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR TO MALABLE PRIOR TO									
EDIC	SEPSIS OR	ASPIRATION F	PNEUMONI	A		1× YES		OF DEAT	TION OF CA	NUSE
AN: M	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	F DEATH YE	S NO	UNCERTAI	N X		1 - YE	S 2 X NO	0
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSPITAL:	26. PLACE OF DEAT	N (Check only one)						
PHYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ☐ ER/Output 28e. DATE OF INJURY	28b. TIME	OF 28c. IN.	ne 5 Residence	6 ☐ Other (Specify) 28d. DESCRIBE NOV	INJURY OCCU	RED		
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 🗆	YES 2 NO					
TED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, si	treet, factory, offic	20	281, LOCATION (Stree City or Town, Ste	t and Number or te)	Rural Route Num	ber,	
COMPLE		CIAN: To the best of my knowledge: On the bests of examination							nner ea stu	ned.
ш	29b. SIGNATURE AND THILE OF CERTIFIER				29c. LICENSE NUI			SIONED (Month, D		
TO B	30. NAME AND ADDRESS OF PERSON WHO	MD COMPLETED CAUSE OF THE	ATN OTEM 27 CT	Orize1	AU4764	35 AL 3065	1 05	TOBER	15,1	1995
	0	J UNION ME	MORLAL HO		201 E.UN	INERSITY ;	>kwy I	SOCTIMA	1c 7	1218
	31. DATE FILED (Month Day Year)	32. NEGISTRAR'S SONA					,			(1
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BALTIMORE, MARYLAND 21215-0020	av be retained by the hospital or attending physician
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BALTI	ours after death.
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30X 68760	te be executed within
P.O. E	th certifica
ION OF VITAL RECORDS, P.O. BOX 68760.	requires that the dea
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within explorers after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	Items11,19a 103095 F	ilmG728 W.H	.per F/H	0	5 31087				
	1 - FOR STATE OF MARY		MENT OF HEALTH AND NEATE OF DEATH	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) SUSAN BAEI	R		2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH				
	219-66-2922-10M2×F	YRS. MO	FUNDER 1 YEAR IF UNDER 24 HRS. WITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) Maryland				
TOR	9a. FACILITY NAME (If not institution, give street and number) RESIDENCE OF DECEMENT	96	COLUMBI-	474 9c. 00	OWARD .				
DIRECTOR	10a. STATE 10b. COUNTY Howard Count		OWN OR LOCATION KESVILLE		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	19. STREET AND NUMBER 979 Day Rd.		101. ZEP CODE 217-5	64	CITIZEN OF WHAT COUNTRY?				
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed Divorced 12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 NO	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Maxican 1 YES 2 70 Specify	n, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify: White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	ille. Do NOT use re	t done during most of working others.)	16b. KIND OF BUSINESS/I					
	12 17. FATHER'S NAME (First, Middle, Lest) Francis Henry Baer	Clerk	18. MOTHER'S NAI	Clerical ME (First, Middle, Melden Surname 1 C. Conley					
BE	19s. INFORMANT'S NAME (Type/Print)								
2	Mrs. Helen C. Baer		press (Street and Number or Bural By Road Sykesvil		ZID Code)				
	20a. METHOD OF DISPOSITION	- City or Town, State Ostead, MD							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Buan L. Had	22. NAME AND ADDRESS OF FAC HAIGHT FUNES		Box 195)					
	23. PART I. Enter the diseases, or complications and cause of shock, or heart failure. List only one cause or	sed the death, Do not	anter the mode of dying, such	h as cardiac or respiratory	arreat, Approximate				
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	AS A CONSEQUENCE OF:	metastatic	- Ovarian ca	Interval Between Onset and Death				
ATION	Sequentially list conditions, if any, leading to immediate b. Due to (on As a consequence of):								
ERTIFICATION	couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	AS A CONSEQUENCE OF):							
O	PART II. Other algorificent conditions contributing to death	h but not resulting in the	he underlying ceuse given in i	Part I. 24a. WAS AN AUTOPS PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE			10	1 YE\$ 2 NO				
Š	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpettent 2 FR/O		THER:	100					
BY PHYS	1 YES 2 NO 1 Inpetient 2 ER/O 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 2 Accident 3 Acci	RY 28b. TIME OF		8 Other (Specify) DZ 28d. DESCRIBE HOW INJURY O	IEN MS U				
8		URY — At home, farm, stree Specify)	it, factory, office	281. LOCATION (Street and Numb City or Town, State)	er or Rural Route Number,				
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my kn one) 2 MEDICAL EXAMINER: On the best of examina								
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALLSE OF	in Mi	D · 29c. LICENSE NUM D433	18ER 29d. D	ATE SIGNED (Morith, Day, Year)				



30. NAME AND ADDRE

30. NAME AND ADDRESS ST. 1. ST. DAY JUNE 11 Day June 1995

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A REGISTRAR'S SIGNATURE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 the feath. Page 6 may be retained by the hospital or attending physician.

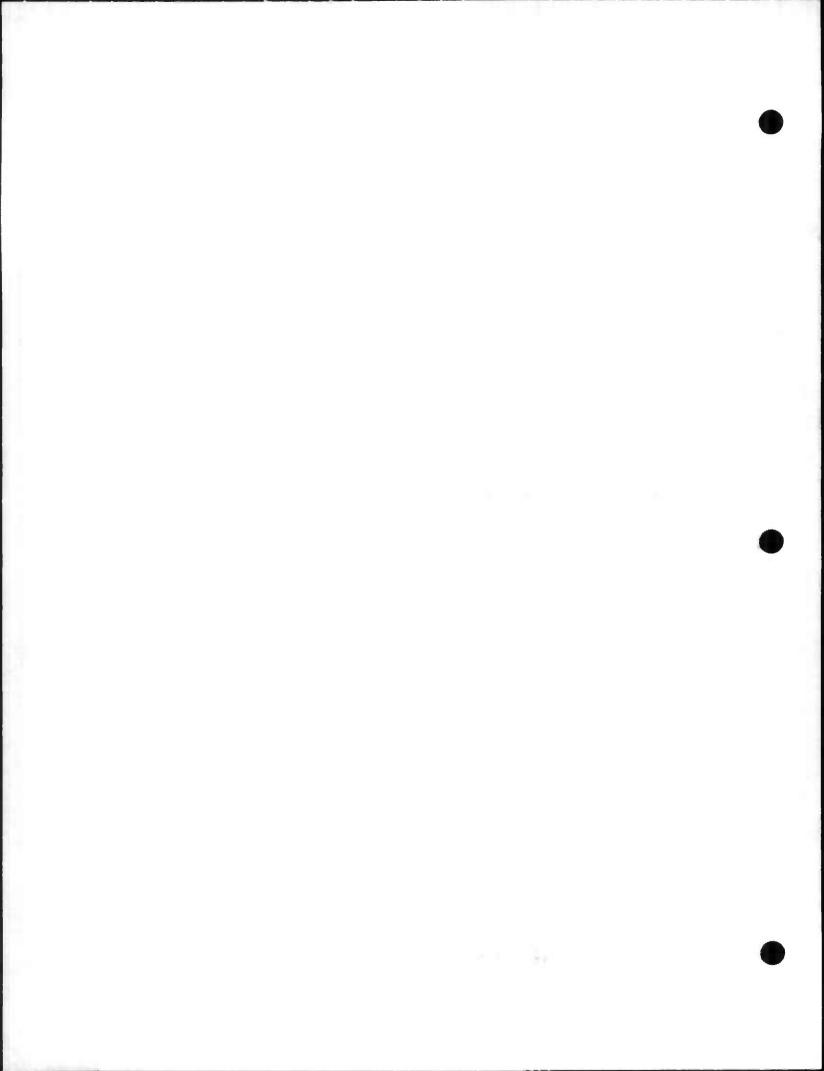
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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR		CERTIF	ICALE O	F DEATH	REG. N	IO.			
1	1. DECEDENT'S NAME (First, Middle, Last) Ruth Bryant					2. DATE OF DEATH MONTH OCTOBER	DAY 1.0	YEAR 1.0 FF		
3	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Pay Year)	T	S. BIRTHPLACE (State or Foreign		
		1 🗆 M 2 💢 F	34 YRS.	MONTHS DAYS	HOURS MIN.	Country)				
_	9a. FACILITY NAME (If not institution, give s				OR LOCATION OF DE	ATH	9c. COUN	TY OF DEATN		
Ď.	1027 Cathedral S	creet-Apt.	C	Baltin	nore					
3EC	10a, STATE 10b, COUNTY	,		Y, TOWN OR LOC	ATION			10d. INSIDE CITY		
ā	Maryland		Bal	ltimore				1 YES 2 NO		
AAL	100. STREET AND NUMBER	tract lat 5			Of. ZIP CODE		EN OF WHAT COUNTRY?			
FUNERAL DIRECTOR	1027 Cathedral St				21201		u.s.A.			
FU	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	8 2 NO	It yes,	ECENDENT OF HISPAN	n, Puerto Rican, etc.)	Yes or No-	14. RACE — American Indian, Black, White, etc, Specify: WN LC		
BY	3 Widowed 4 Divorced	IF TES, GIVE WAR OR	DATES	104	ES 2 NO Specify	<i>f</i> :		Specify: WYLALL		
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	work done during i	TION nost of working	16b. KIND OF I	USINESS/INDL	JSTRY		
37d	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	se retired.)		ľ				
OM	17. FATHER'S NAME (First, Middle, Last)		<u> </u>		18 MOTHER'S NA	ME (First, Middle, Maid	an Sumamal			
BE C					131 333 1121 2 112	me (i rat, imoord, imalo	on Surraine)			
TO B	19a, INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Stree	and Number or Rural F	Route Number, City or 1	own, State, Zip (Code)		
۲										
	20e. METNOD OF DISPOSITION 1									
			n. 1. 0:.	22. NAME	AND ADDRESS OF FA	CHITY				
	21. SIGNATURE OF FUNERAL SERVICE LIC	Konala u	aae, ver.	State	Anatomy	Board-65	5 W. Bo	ultimore Street		
-4	23. PART i. Enter the diseases, or o	complications that cause	ed the death. Do r	Rm. BC	126-Baltin	nore, Mari	pland	21201-1559		
	snock, or neart fellure.	List only one ceuse on	asch line.	ot antai the n	ioda oi dyilig, suci	n as cardiac or ras	piratory arre	intarvai Between		
1	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Responsible of the condition of the cond									
ĺ	DUE TO (OF AS A CONSEQUENCE OF):									
NO	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION										
FI	CAUSE (Disease or Injury that initiated events	Our TO 10th AS A CONSEQUENCE OF): Chromic Rapad INSI Spicianus								
ERT	resulting in death) LAST	Chron	ic Ropal	INSUS	Treianna					
	PART ii. Other significant condition		,			Part I. 24a, WAS	IN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
EDICAL	- PAI			,		PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MED						1 TYES	2 WO	OF DEATH?		
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH YE	S NO	UNCERTAIN	10				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	N (Check only on OTHER:	9)					
l¥S	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Ou		4 - Nursing Ho	me 5 Residence					
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		URY	JURY AT ORK? YES 2 NO	26d. DESCRIBE NOV	INJURY OCCU	JRED		
ĕ l	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJUR	TY — At home, farm, s			28t, LOCATION (Street	t and Number o	or Rural Route Number,		
ĬĬ.	4 Nomicide determined	building, atc. (Sp	ecify)			City or Town, Sta	(0)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my kno	wledge, death occurre	d at the time, da	te and place, and due	to the cause(s) and m	anner as stated	d.		
Ö								cause(s) and manner as atated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d, DATE	SIGNED (Month, Day, Year)		
2) M	D		1/37	299	- /	10/5/95		
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	EATH (ITEM 27) (Type,	Print)	=3x6			,		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NĂTURE	1	000					
		A . B.	i P .	48						
		Vale Die	WILLIAM BANC	W.						



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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

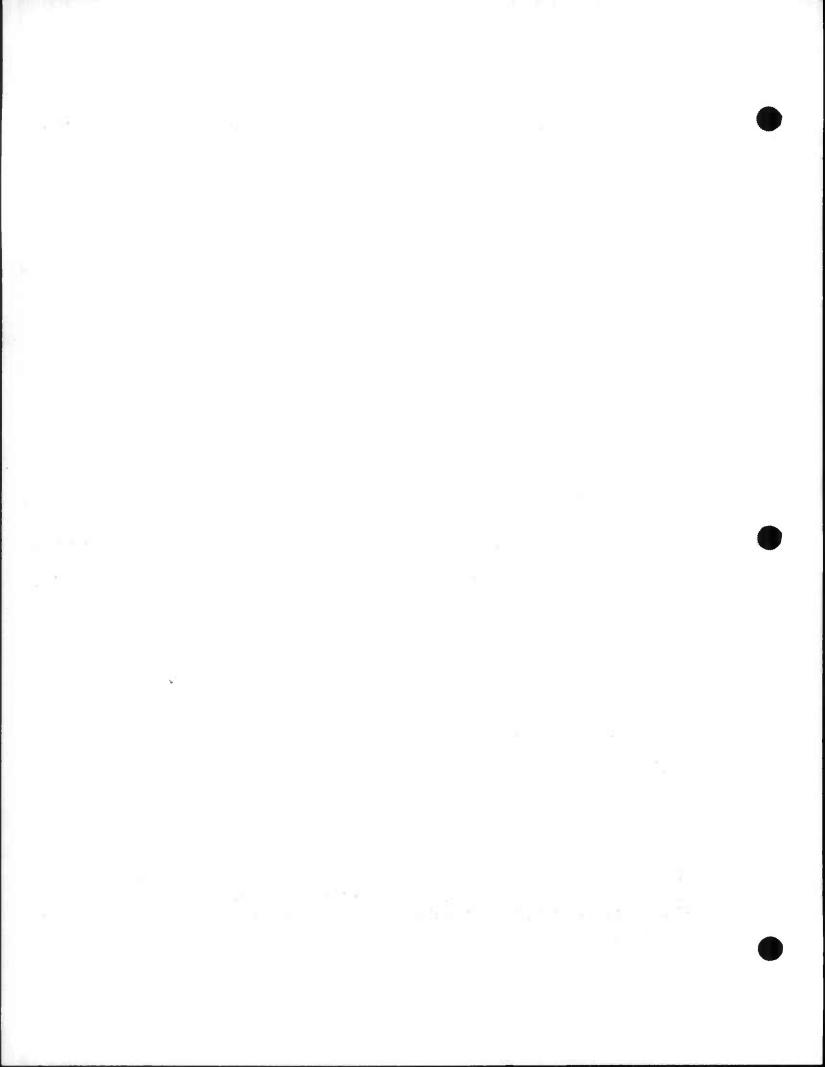
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE C				3. TIME OF DEATH	
	DORIS Bradley						MONTH DAY		95 4 AM W		
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthde)	F UNDER 1 YE	AR IF UNDER 24 HRS		- (2				
	21/ 12 1002			MONTHS DA		(Month,	Day, Year)		Country	PLACE (State or Foreign	
		1 🗆 M 2 🛣 🛣	83 YRS.			10-	26-1	911	Mar	y yland	
	9e. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TO	YN OR LOCATION OF	DEATH		9c. COUN	ITY OF D	EATH	
R	Johns Hopkins H	Ravviow H	nenital	Rai	timore			N(N/A		
K	RESIDENCE OF DECEDENT	Jayview 11	Ospitai	ј Ба.	CIMOLE			1/4	/ A		
DIRECTOR	10e. STATE 10b. COUNTY		10c. C	ITY, TOWN OR L	CATION					10d. INSIDE CITY	
뜽	Md.	N/A		Doll + de	0.11.0					LIMITS?	
5	10e. STREET AND NUMBER	N/A		Daltin	Baltimore					1 X YES 2 NO	
*								ZEN OF W	HAT COUNTRY?		
FUNERAL	321 N. Ellwood	Avenue			21224 U.S.A.						
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE -						
LL.	1 Never Married 2 Married	FORCES? 1 Y	ES 2 XNO	If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 X XO Specify:					— American Indian, White, atc.		
BY	3∑Widowed 4 □ Divorced	IF IES, WITE WAS OF	DATES	10	TES 2 KU AKO Spe	city:			Whi	y: + o	
Ω	15. DECEDENT'S EDUCA	TION	16. DECEDENT	S USUAL OCCUP	ATION	405					
E	(Specify only highest grade of	ompleted)	(Give kind o	f work done during use retired.)	most of working	100, 1	UND OF BU	SINESS/IND	USTRY		
" "	Elementary/Secondary (0-12)	College (1-4 or 5+)									
2				wife			OWN Home				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First, Mi	ddle, Malden	Surname)			
	John Perry	7			Mary	A 7	len				
H	19a. INFORMANT'S NAME (Type/Print)		19h MAII II	C ADDRESS (SH	net and Number or Run			- Contract	0.41		
9										, =	
	Vincent Gugliuz	za	243	Riage	Avenue,	Towso	n, Ma	. 2	128	6	
	20a. METHOD OF DISPOSITION 1 Buriel 2 □ Cremation 3 □ Remove		20b. PLACE AND DAT		,			CATION —			
	4 Donation 6 Other (Specify)	a. nom state	Parkwoo	d Ceme	terv 1	0/14	Ba	ltim	ore	.Md.	
	21. SIGNATURE OF FUNERAL SERVICE LICE		1		AND AODRESS OF					,	
	. ///	-14	M						2123	11	
	1000000	29 KG		Lil	y & Zeil	er Inc	. 190	1 Eas	tern	Avenue	
	23. PART I. Enter the diseases, or co	mplicetions thet cau	sed the death. Do	not enter the	mode of dying, si	ich as cardii	C Of reap	ratory arm	nat.	Approximate	
	snock, or neert reliure. Li	at only one cause or	each line.							interval Between	
	IMMEDIATE CAUSE (Final disease or condition	1.1								Onset and Death	
	resulting in death)	DUE TO ON A	oxemia	-					12 days		
					-					1	
Z		ASDIK	otion T	NPILIM	NAIA					12 chis	
2	Sequentially list conditions. A Spiration DNeumonia 12 days Due to (or as a consequence of):										
ΧI	cause. Enter UNDERLYING	if any, reading to infinediate									
CERTIFICATION	cause (Disease or injury that initiated events										
E	resulting in death) LAST			,.						i I	
ij I	d										
	PART ii. Other algnificent conditions	contributing to deet	but not resulting	in the under	dno ceuse alven i	n Dort I	4- MMO AN	ALITODON	Lan		
EDICAL	PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED?					24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO				
ă	1 □ YES 2 √NO						COMPLETION OF CAUSE OF DEATH?				
ME							1 YES 2 NO				
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
Y	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one)										
豆	EXAMINER? HOSPITAL: OTHER:										
₹ I		Inpetient 2 - ER/O	utpatient 3 DOA	4 🗆 Nursing I	Ioma 5 🗆 Residence	8 🗆 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	26e. DATE OF INJUR (Month, Day, Yea		ME OF 26c.	INJURY AT WORK?	28d. OESC	RIBE HOW I	NJURY OCC	URED		
BY	1 Natural 5 Pending 2 Accident Investigation	(' "		YES 2 NO						
	2 Cutolda	2 Suitable 28e PLACE OF IN HIRV - At home form etc.			Mica	281 LOCAT	ATION (See also divine a particular divine a p				
	4 Homicide determined building, etc. (Specify)							OCATION (Street and Number or Rural Route Number, Ity or Town, Stete)			
<u> </u>											
COMPLET	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) end manner as stated.										
<u>≥</u>	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.										
	SOL SIGNATURE AND THE OF OFFICE										
H	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE N	UMBER		29d. DATE	SIGNED	(Month, Day, Year)	
2	MUCCan, MI				14634	\circ		10	0/12	2195	
F	38. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	OEATH (ITEM 27) (Typ	e, Print)	Acleau	MD		-			
18											
JI.	JOHNS LANVING KA	LANDON LL-	mode () Che								
	31. DATE FILED (Month, Day, Year)	JUPU HE	GNATURE	140 8	astern	Ave	Bal	MON	er	D 21224	
	31. DATE FILED (Month, Day, Year) OCT 1 7 1995	32. REGISTRAR'S SH	GNATURE	140 8	astern	Ave.	Bal	IMOY	er	D 21224	

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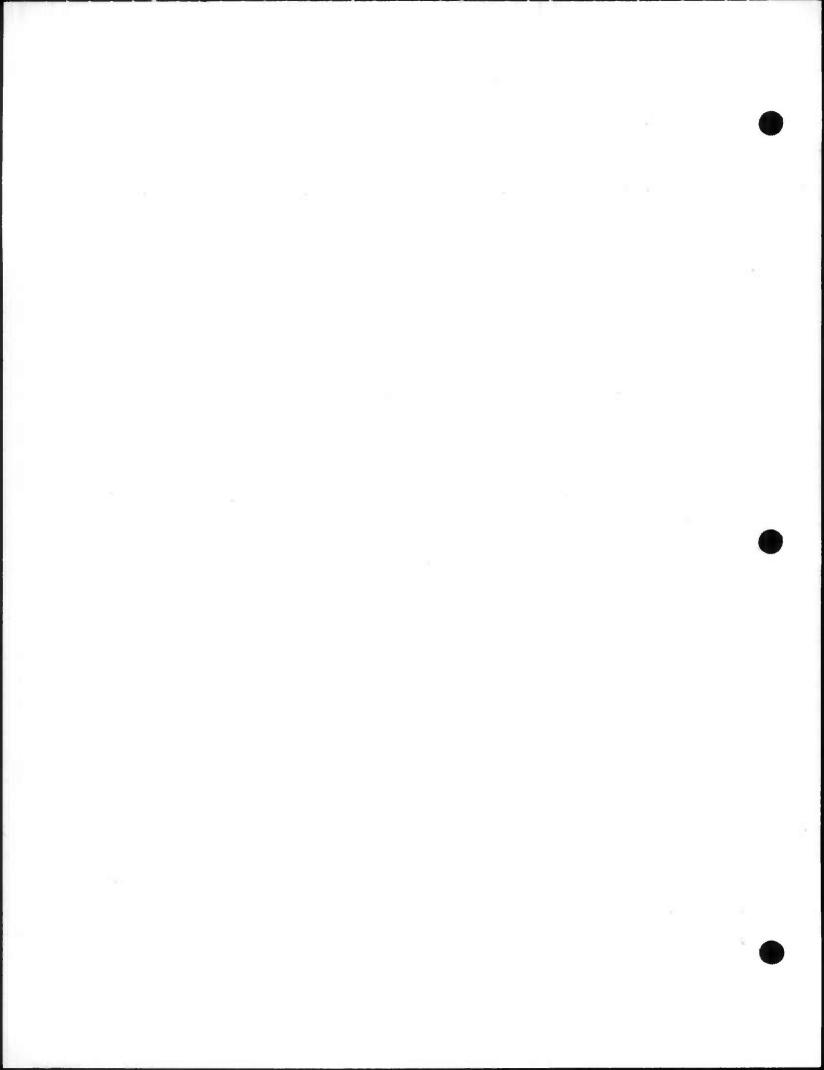
BALTIMORE, MARYLAND 21215-0020

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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be execu	cian and ior to buri	raumatic	
certificate	ding physi- tygiene pri	r other t	
the death	y the atten	Injury, o	
uires that	signed b	ws any	
law requ	as been Jept. of	23 sho	
IAN: The	tificate h	or item	
NG PHYSIC	fer this cer	marked,	
ATTENDI	cTOR: A	28 Is	
TAL DR	AL DIRE	If Item	
HOSPI	E FUNER	RTANT	
10	日第	IMPO	

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) Francis	BURKE				2. DATE OF DEATH October 1	3. TIME OF DEATH 9:59 am. M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	HPLACE (State or Foreign			
DIRECTOR	220-07-4170 se. FACILITY NAME (If not Institution, give stre-	1X M 2 F		MONTHS DAYS	HE DAYS HOURS MIN. May 5, 19			921 Maryland		
	Franklin Square Hospital			96. CITY, TOWN OR LOCATION OF DEATH ROSSV111e			Baltimore county			
EC	10a. STATE 10b. COUNTY	10c. CITY	TOWN OR LOCAL	FION			10d. INSIDE CITY			
	Md. Baltimore			White Ma						
RAI				10	. ZIP CODE			WNAT COUNTRY?		
FUNERAL	11602 Jerome Ave. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARIN			21162				A		
BY FU	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Widowed 1 Married FORCES? 1 M YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y If yes, apecify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:			Black, White, etc. Specify:			
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S U	SUAL OCCUPATION	ON.	ASS VIND OF BU	001500 1110105	White		
COMPLETED	(Specify only highest grade co	(Specify only highest grade completed) (Give kind of v				160, KIND OF BU	16b. KIND OF BUSINESS/INDUSTRY			
17	10th	Photographer			r					
Ö	17. FATHER'S NAME (First, Middle, Last)	11100091				n/a THER'S NAME (First, Middle, Meiden Surneme)				
BE	unknown				unkr	nown				
TO E	19a. INFORMANT'S NAME (Type/Print) 19b. I			ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
-	Rachel Berger		432	l Flin	t Hill	Drive Ow	ingsMil	1s Md.2111		
	20a. METHOD OF DISPOSITION	al from State 20b	PLACE AND DATE OF	DISPOSITION (N)	ame of	OATE 20c 10	CATION - CITY or T	own State		
	4 Donation 5 Other (Specify)	H	olly Hi			0/16/95	Baltimo	ore Md.		
	21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY COMPANIE AND ADDRESS OF FACILITY COMPANIE AND ADDRESS OF FACILITY									
	N. Juru	R. Tury Cornelly Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221								
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	mplications that caused at only one cause on e	the death. Do no	t enter the mo	de of dying, suc	ch as cardiac or reap	Iratory arrest,	Approximate Interval Between		
- 1	IMMEDIATE CAUSE (Final					Onset and Death				
	disease or condition resulting in death)	ar Arrhyt	2 hours							
			ONSEQUENCE OF):							
O	Sequentially list conditions, b.							l week		
¥.	If any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	that initiated events	CAUSE (Disease or Injury C.								
	resulting in death) LAST									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS									
CAL	PERFORMED? AM							AWAILABLE PRIOR TO COMPLETION OF CAUSE		
ED	OF						OF DEATH?			
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN									
IAN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
Sic	EXAMINER? 1 YES 2 NO HOSPITAL: 1 OTHER: OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)									
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		26d. DESCRIBE HOW	NJURY OCCURED			
BY	1 Netural 5 Pending 2 Accident Investigation				ES 2 NO					
	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street building, etc. (Specify)			eet, factory, offic		26f. LOCATION (Street City or Town, State)	Route Number,			
	4 Homicide detarmined									
COMPLETED	29e. CERTIFIER (Check only one) 1 A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and placs, and due to the ceuse(s) end manner as stated.									
ξ.	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.									
BE	296. SIGNATURE AND TITLE OF CERTIFIER , 29c. LICENSE NUMBER 29d. DATE SIGNED (N									
5	RD1913 DOCT				▶0ctobe	ober 13, 1995				
	G. Davis, M.D. 9000 Franklin Square Drive Baltimore, MD 21237									
	OCT 1 71995 July Sauden Aurell									
	0		>							

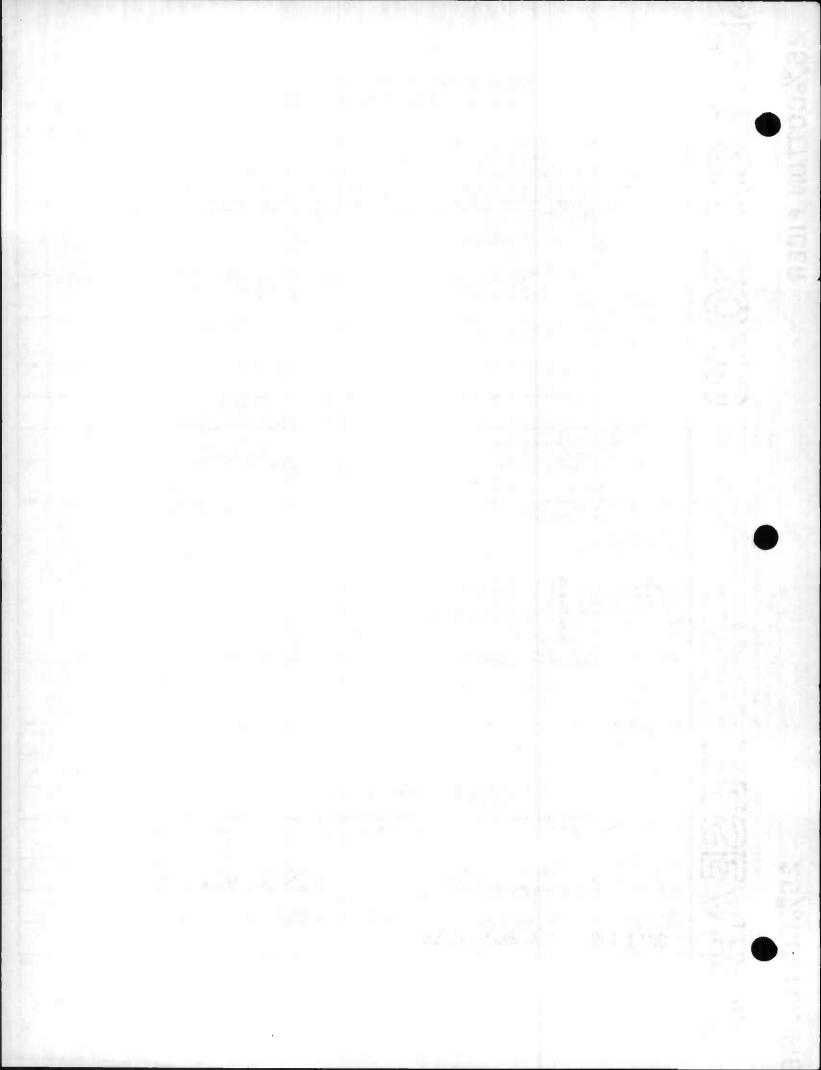


BALTIMORE, MARYLAND 21215-0020	death certificate be executed within a fours after death. Page 6 may be retained by the hospital or attending physicia	a attending physician and completely filled in by the funeral director name 5 should be detached for use as the huristic
MAR	retained	5 chould
MORE,	age 6 may be	director nane
BALTI	fter death. P	the funeral
	ROURS 3	filled in by
.68760,	executed within	and completely
S, P.O. BOX 68760,	certificate be	ding physician
S, P	death	a attan

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (Fin	YOSEF	MAYER		BAR	SKY				2. DATE OF D	EATH DAY	YEA 199.	1 1 1	
	4. SOCIAL SECURITY NUM 214-13-5486	5	5. SEX 1 X M 2 F	6. AGE (In yrs. les 17	t birthday) YRS.	IF UNDER	t YEAR DAYS	IF UNDER	24 HMS. MIN.	7. DATE OF B		6 84	OUNTRY) SHINGTON, D	
ECTOR	90. FACILITY NAME (# not MT. WASHING RESIDENCE OF DE	STON PI					OR LOCATI	ON OF DE	ATN	9c.	N/A	OF DEATN		
DIREC	100. STATE MARYLAND	10b. COUN	N/A		10c. CIT	Y, TOWN C		TION LTIM	ORE				10d. INSIDE CITY LIMITS? 1XXYES 2 \(\text{I NO} \)	
IERAL	3711 GLENGY		Ξ .				10	1. ZIP COD		215	101		OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 X Never Married 2 C 3 Wildowed 4 Div		FORCES?	NT EVER IN U.S. AF 1 YES 2 VI WAR OR DATES	IMED NO		f yes, sp		n, Mexica	IIC ORIGIN? (Sp n, Puerto Rican 7			NACE — American Indian, Black, White, atc. Specify: WHITE	
MPLETED		CEDENT'S EDinly highest gred (0-12)		(G	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working a. Do NOT use retired.) STUDENT					166. KIND OF BUSINESS/INDUS			STRY	
E C0	17. FATHER'S NAME (Flist, CARL	BARS	SKY			18. MOT		ME (First, Middle ISA	, Maiden Sumi	ame)	GERTEL			
5	MR. CARL	Y 19						ALTIMO						
	20e. METNOD OF DISPOSITION 1 Taburiel 2 Cremation 3 Removal from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of comptler), crematory or other place) AGUDATH ISRAEL 20c. LOCATION — City or Town, State 10-13-1995 — ROSEDALE,													
	21. SIGNATURE OF FUNER	AL SERVICE L	1/	rnoc	~	22. S	I JC		SON		., INC			
CERTIFICATION	Sequentielly list cond if any, leading to imm cause. Enter UNDERL' CAUSE (Disease or inj that initiated events resulting in death) LA	ediats YING jury	a MULT	O (OR AS A CONSE	OUENCE OF	d	efic	cleni	cÝ				congenitation (at birth	
MEDICAL	PART II. Other signific	ant condition	ne contributing to	o deeth but not i	reculting	in the ur	dsriyin	g csuse	given in		WAS AN AUTO PERFORMED YES 2	OPSY ?	24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERBED EXAMINER?	TO MEDICAL	HOSPITAL:			OTHE		LACE OF D	DEATN (Che	eck only one)				
BY PHYS	1 YES 2 NO 27.MANNER OF DEATH 1 Accident	Pending Investigation	26a. DATE O	ER/Outpatient 3 F INJURY Day, Year)	28b. TIM		28c. IN.	JURY AT ORK? YES 2		8 Other (Spi 28d. DESCRIB		TY OCCURE	0	
TED B	2 Culalda	Could not be determined	28e. PLACE building	OF INJURY — At he I, atc. (Specify)	ome, farm,	etreet, fact	ory, offic	ca .		28f. LOCATION City or Tox		lumber or Ru	iral Route Number,	
COMPLET	onel		SICIAN: To the best of										ree(s) and manner as state	
TO BE	30. NAME AND ADDRESS O	rell	THO COMPLETED CAN	Roun USE OF DEATH (ITE	M 27) (Type	, Print)		1)4	FASE NUM	940	2	10/1	NED (Month, Day, Year) 3/9.5 2/20 G	
	31. DATE FILED (Month, De OCT 1 7 1	995	32. REGISTR	IAR'S SIGNATURE	Wit	< 06	CR.	SAM	IE.	DG 1+70	nore	MO	21200	



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

OFCISTOAD CEDTIFICATE OF DEATH	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYG	HENE
CERTIFICATE OF DEATH REG.	REGISTRAR	CERTIFICATE OF DEATH REG	NO.

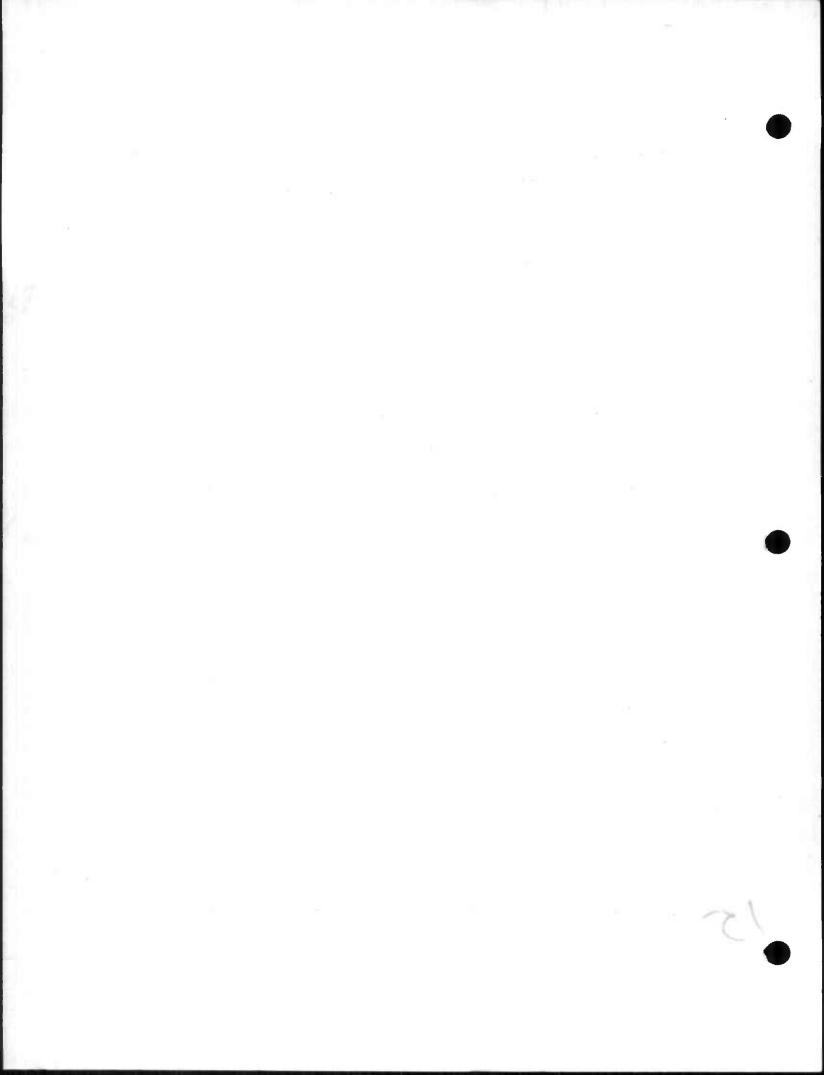
	1 - FOR STATE OF MARYLAND A	DEPAR	TMENT	OF HI	EALTH DEAT	AND I	MEN	TAL HYGIENE REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. D.	ATE OF DEATH	,	WEAR	3. TIME OF DEATH
	JAMES BERRY						00	TOBER	13	1995	Z100 M
-	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Ia:		IF UNDER		IF UNDER	24 HRS.	(N	ATE OF BIRTH fonth, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	215-12-3380 ¹ᡚм²□F 75	YRS.					C	08-23-2			MD.
Œ	9e. FACILITY NAME (If not institution, give street end number) DEATON MEDICAL CENTER				MORI		EATH		9c. COU	NTY OF D	EATH
510	RESIDENCE OF DECEDENT		DA	LILI	MORI	2			IN / A	Α.	
DIRECTOR	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWH O	R LOCATIO	ON						10d, INSIDE CITY LIMITS?
	MD • N/A	BA	LTIM								1 XYES 2 NO
RA					ZIP CODE				10g. CITI		HAT COUNTRY?
FUNERAL	601 S. CHARLES STREET 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF	BMED.	12 W		1230		#C 08	IGIN? (Specify Yes	N-	USA	
F	1 Never Married 2 Married FORCES? 1 YES 2 NEVE WAR OR DATES	NO.	и	yes, spec	cify Cuber	ı, Mexica	n, Pue	rto Rican, etc.)	or Mo.—	Black Speck	— American Indian, , White, etc.
) BY	3 Wildowed 4 Divorced				X	ороспу				арви	BLACK
TE	15. DECEDENT'S EDUCATION 16a, DE (Specify only highest grade completed)	ECEDENT'S	WORK done done done retired.)	CUPATION uring most	t of working	7		166. KIND OF BUSI	NESS/IND	USTRY	
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) UNK UNK		se retired.)					UNK			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18, MOTH	ER'S NAI	ME (Fir	rst, Middle, Meiden S	Sumama)		
BE C	UNK			- 1-	UNK		37,44				
TO B								lumber, City or Town,			
-						E, E	BAI	TIMORE	, MI	D •	21201
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) MT. Z					1 D 17	F	ATE 20c. LOC			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ADDRES)-17 LAN	וטעפ	WNE,	MD.
	· ////////							IE F/H			
_	23. PART I. Enter the diseases, or complications that caused the da	eth. Do r	ot enter t	38 T	of dyl	ILM	10R	STREE	T :	2121	7 Approximate
	shock, or heart fellure. List only one cause on each line	9.							,,,,		Interval Between Onset and Dasth
	disease or condition resulting in death)	1	en	ol	F	ar	Ke	ere			2 Weel
	DUE TO OR AS A CONSE	OUENCE OF	F):	-	- 01						21.8
NO	Sequentially list conditions,	and the same of the same of		2	217		1				Lung
CERTIFICATION	csuse. Enter UNDERLYING	1	"A	20	in	ct	to	r			manlo
Ĕ	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSECUTION OF AS	OUENCE OF	P):								1
ERI	resulting in death) LAST										
CALC	PART II. Other significant conditions contributing to deeth but not r	resulting i	in the unc	lerjying	cause g	lven in I	Part I.	. 24a. WAS AN A		24b.	WERE AUTOPSY FINDINGS
S	mal mulation about	om	ne	NE	sec	and	_	PERFORM			AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI	Deheschee										OF DEATH? 1 YES 2 NO
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA				UNC	RTAIN	۷ 🗆				
PHYSICIAN:	EXAMINER? HOSPITAL:		OTHER:								
HYS	1 ☐ YES 2 ☑ NO	DOA 28b. TIM		ng Home 28c. INJUI		idence		ther (Specify) DESCRIBE HOW IN.	III O O O O	WINED.	
	1 Natural 5 Pending (Month, Day, Year)		URY M	WOR	K?	NO	200.	DESCHIBE HOW IN	JUHY OCC	UHED	
р ВУ	2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify)	me, ferm, s	street, factor	ry, office			28f. L	OCATION (Street en	d Number	or Rural A	oute Number,
	4 Homicide determined						C	Olty or Town, State)			
PLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, de	ath occurre	d at the tin	ne, date e	nd place,	end due	to the	cause(s) end mann	er as state	ed.	
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination end/or i	Investigatio	n, in my op	inion, des	ith occure	d at the t	time, d	lete and place, end	due to th	e cause(s)	end manner as stated.
BE	29h. SIGNATURE AND TITLE OF CERTIFIER	01	7	- 1	29c. LICEI	NSE NUM		10			(Month, Day Mer)
10		ec	•		110	//	10	60	>/	0-1	5-50
	A0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEL ROLANDO GOCO. 707 F. FORT			-	T (*) =						
	ROLANDO GOCO, 707 E. FORT 31. DATE FILED (Month, Day, Year)	AVE	NUE,	, BA	TLT.T	MUR	E	MD. 2	1230)	
	nett 7 1995 Juli Studior Randa	14									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		STATE OF N					EALTH AN		ENTAL HYGIENI REG. NO.	Ē		
1. DECEDENT'S NAME (First	, Middle, Last)				I CALL		DEATH	T	2. DATE OF DEATH			3. TIME OF DEATH
FRANK	PAU	L	CHASI	Ξ					OCT. 11	, 19	95	1830 P M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. las	11	IF UNDER	R 1 YEAR	IF UNDER 24 H	_	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign y)
212-56-700		1 📉 M 2 🗌 F	46	YRS.					Sept. 27,1			ryland
90. FACILITY NAME (# not in GUNPOWDER					9b. CITY		R LOCATION C		тн		AT.T	EATH [MORE
RESIDENCE OF DEC		B TAIKK				Bali	timore					HOKE
10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCATI	ON					10d. INSIDE CITY LIMITS?
Maryland	Ва	ltimore					Perry	На	11			1 TES 2X NO
10e. STREET AND NUMBER						10f.	ZIP CODE	0		10g. CIT	ZEN OF V	VHAT COUNTRY?
18 Gunvie	w Farm						2112				.S.A	
1 Never Married 2 X 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RO		If yee, spe		axican,	C ORIGIN? (Specify Yea , Puarto Rican, etc.)	or No-	14. RACE Black Speci	- American Indian, t, White, atc.
	EDENT'S EDU		18a. DE	CEDENT'S	USUAL C	CCUPATIO	N		16b. KIND OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (ly highest grade 3-12)	College (1-4 or 5	- Ma	. Do NOT u	se retired.)		t of working		0.16		1	,
		4		Mus	icia	n			Self		Toye	a .
17. FATHER'S NAME (First, A									E (First, Middle, Maiden			
Frank Ch	arnask	.y	1 40		100000	0.10	Mar	_				
Gail L. Ch		(wife)							oute Number, City or Town Perry Hall			128
20a. METHOD OF DISPOSIT	TION		20b. PLACE	AND DATE	OF DISPO	SITION (Nar	ne of	, .			City or To	wn, State
4 Donation 5 Other		ioval trom Stata	Green	Mou	nt C	rema	tory		10/13 Bal	timo	re,	Maryland
21. SIGNATURE OF FUNER	IC SERVICE LIC	CENSEE					D ADDRESS O		eral Homes			
1	-7.	bell	1						i., Baltim			21236
23. PART I. Enter the d	liseeses, or	complications the	t caused the de	eath. Do	not ente	r the mod	de of dying,	such	aa cerdiac or respi	ratory ar	rest,	Approximate
IMMEDIATE CAUSE (FI		Elat only one cac	wa on acci iin	J.								Onset and Death
disease or condition	\rightarrow	a. SHOTG				EAD,	CONT	ГАС	CT			
		DUE TO	(OR AS A CONSE	OUENCE O	F):							
Sequentially list condit		b. DUE TO	(OR AS A CONSE	QUENCE O	F):							
if any, leading to imme cause. Enter UNDERLY	ING	C.										
CAUSE (Disease or Injuthet initiated events		DUE TO	(OR AS A CONSE	OUENCE O	F):							
resulting in deeth) LAS	" L	d										
PART ii. Other aignifice	ent condition	ns contributing to	deeth but not	resulting	in the u	nderlying	ceuse give	n In F			246	. WERE AUTOPSY FINDINGS
									1 (X YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
												OF DEATH?
DID TOBACCO L	ISE CONT	RIBUTE TO CA	USE OF DEA	ATH Y	ES 🔲	NO 🗆	UNCER	TAIN	X			X-
25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:	26. PLA	CE OF DEA								
1 X YES 2 NO		1 Inputient 2	ER/Outpatient	B DOA	OTHE		5 🗆 Raalde	ence 8	X Other (Specify)	OOD	S	
27. MANNER OF DEATH	Dec Hon	28a. DATE OF (Month, D	lav. YharLe	28b. TIN	IE OF	28c. INJU	RK?	- 1	28d. DESCRIBE HOW II	NJURY OC	CURED	
2 Accident	Pending Investigation		-95	4:4	17 PM	1 🗆 Y	7.7	°	SURJECT	SHO	JZE	LF
3X X Sulcide 8 — 4 — Homicide	Could not be detarmined	building,	FINJURY — At he atc. (Specify)	ome, form,	atreet, tac	ctory, office	1		281. LOCATION (Street I City or Yown, State) SUNPOWDER	Ind Number	TE CO	RK, BELAIR
29e. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the of	my knowledge, d	eath occur	ed at the	time, deta	and place, and	d due t	o the cause(e) and man	ner sa sti	rted.	
0001	ICAL EXAMINE	On the bests of a	minstion and/or	Investigation	on, In my	opinion, de	eath occured a	at the t	ime, date and place, an	d dua to t	he cause(e) and manner as stated.
296 SOSHATURE AND TITAL	of the second	2/1//	1) 1	,			29c. LICENSI	E NUMI	BER	29d. DA	TE SIGNED	(Month, Day, Year)
LIBOUV	W	anux	7/W				O.C	.М.	.E	▶ C	CT.	12,1995
Mario F.	- 27	12 2	1			read	- Ra	1+	imore M	arv1	and	21201
31. DATE FILED (Month, Day,			D. LLL	rem	ı al	тее	, bd.	J. L.	LINUTE, M	ит ў 1	Cana	21201
OCIT 7199	5 Jul	in Oluder	tarlet									

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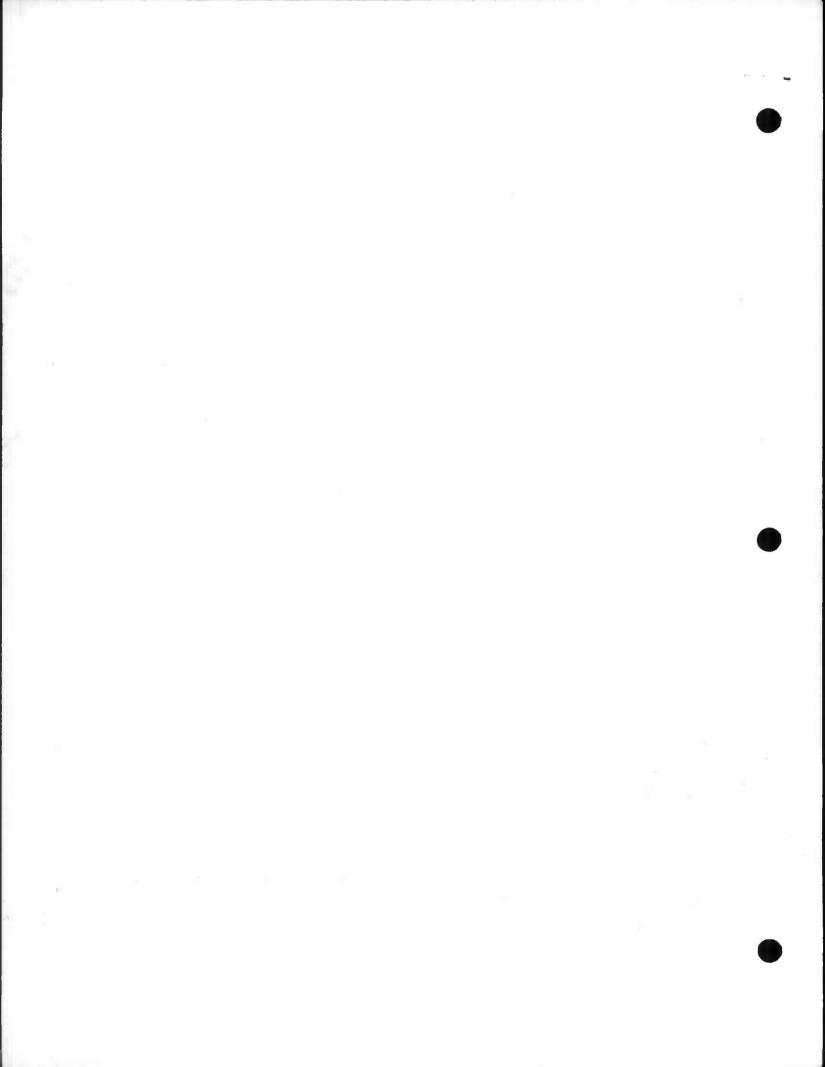
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atter TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. IMPORTANT: If Hem 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.
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JAMES APPIAH
31. DATE FILED (MONIN, Day, Your)
OCT 1 7 1995

							95	31094
	1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPAI CERTIF	RTMENT OF H	DEATH AND			
	1. DECEDENT'S NAME (First, Middle, Last)			-	^	2. DATE OF DEATH		1. TIME OF DEATH
1	DORIS	T,	CU	LOT	TH	MONTH RER		EAR 11 2
	4. SOCIAL SECURITY NUMBER	5. SEX A AGE	(In ure last hirthday)	IE IMOED I VEAD	NE IMPORTO DA LINO			
		75.0		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		BIFITHPLACE (State or Foreign Country)
1 8		- 7	88 YAS.			October 10	1907	Maryland
	9e. FACILITY NAME (If not Institution, give s	treet and number)		96. CITY, TOWN (OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
18	Good Samaritan Ho	osnital		Raltin	nore City	V	1	VIA
5	RESIDENCE OF DECEDENT	7501001		Daiti	HOIC CIC	У	/	711
#	10e. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY
<u>=</u>	Marvland	N/A	l Ra	ltimore	City			
뒫	10e. STREET AND NUMBER		1 00				10g, CITIZEN	
E.	1700 Hanford Rd	5			0101	A	***	
Z		12 WAS DECEDENT EVED	IN II C ADMITO	40 1110 000				
E		FORCES? 1 YES	2 X NO	13. WAS DEC	ENDENT OF HISPA ecity Cuben, Mexico	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.)	or No- 14,	RACE — American Indian, Black, White, atc.
≾	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 TYES	2 NO Specif	fy:		Specify: White
쁘	(Specify only highest grade	completed)	(Give kind of	work done during ma	ON ast of working	16b, KIND OF BU	SINESS/INDUST	'RY
"	Elementary/Secondary (0-12)	College (1-4 or 5 +)						
<u>₹</u>	8 yr s		Home	emaker		0wn	Home	
ᅙ	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	AME (First, Middle, Maiden	Sumame)	
	Joseph	Sharp			Ann		Bloc	bdbt
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural	Route Number, City or Tow	n. State. Zip Coc	de)
	Mrs. Ruth Singer							
		20						
	1 N Buriel 2 - Cremation 3 - Rem	oval from State Cer	metery, crematory or c	ther place				
			Garder					
	A A A A	/ /		22. NAME AF	NO ADDRESS OF FA	Baltimo	ore, Md.	21214
	* tan I Hai	touchile		Leona	nrd .1 Ri			
	23. PART I. Enter the diseases, or o	complications that couse	d the death. Do	not enter the mo	de of dving, suc	ch as cardiac or read	ratory arrest	Approximate
1	shock, or heart failure.	List only one cause on a	each line.				,	Interval Between
1 1		CEDT	10001	14				Onset and Death
	resulting in death)	e. SEFI	ICFIAI	1/\				4 DAY 2
		The second second						00000
2	Sequentially list conditions							4 DA47
ΙĔΙ	if any, leading to immediate				TION			IN WEAK
호		aAIRI	AL TIE	SKILLA	FILOIL			10 1 cuts
E	that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):				
E	resulting in death) LAST	d						
	DARWELL COM I - MI A MI							
₹				in the underlying	g cause given in			24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
품	ISCHEINIC CA					1 YES 2	NO	COMPLETION OF CAUSE OF DEATH?
	CONGESTIVE	HEARIF	-AILUK					\ /
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH Y	S I NO I	UNCERTAIL	N M		7
¥.	25. WAS CASE REFERRED TO MEDICAL				0.10211111	.,		
잃		HOSPITAL:	metions 2 - BOA	OTHER:				
¥							NI HIEW COOKING	
	1 Natural 5 Pending	(Month, Day, Year)		URY WO	RK?	280. DESCRIBE HOW I	NJUNY OCCUME	10
BY	2 Accident Investigation							
	Count not be	building, etc. (Spe	f — At home, ferm, cify)	street, factory, office		281. LOCATION (Street I City or Yown, Stete)	and Number or R	tural Route Number,
E	The monte of the management of							
집	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the beat of my know	rledge, death occurr	ed at the time, date	and place, and due	to the cause(a) end mer	ner as stated.	
N N	TOTAL PROPERTY MANAGED TO PROPERTY STATE OF DEATH PROPERTY STATE OF DAY IN THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERT							
BE	1 Domin	MM			Z9C, LICENSE NUI	MBER C O G	29d. DATE SIG	OBER 15TH 1995
2	30. NAME AND ADDRESS OF PERSON WHO				04+1	684	OCI	OREK 12, 114R
	JU. ITAME AND ADDRESS OF PERSON WHO	J COMPLETED CAUSE OF OF	ALM (ITEM 27) /Tone	(-Print)				

GOOD SAMARITAN HOSP, 5601 LOCH RAVEN BLVD, BALTO, MD



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MEETAGULAT

31. DATE FILED (Month, Day, Year) 0CT 1 7 1995

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9 HERESA AWTHORNE .19 OCTOBER AM 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 217-56-9633 HOURS 1 - M 2 X F md 6,)an Pages 1. 2, 3 should 9a., FACILITY NAME (If not institution, give stree 9b. CITY)TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Huspi bor DIRECTOR N D RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY mo Salto 1 X YES 2 NO hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlal-transit permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Reedbire 21225 Ave SIA Ui 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify, Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried IF YES, OIVE WAR OR DATES Black BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY tary/Secondary (0-12) College (1-4 or 5+) Security Secun A (mare 17. FATHER'S NAME (First, Middle, USS) 18. MOTHER'S NAME (First, Middle, Malden Surname To BE Barnes notified 19n. INFORMANT'S NAME (Type/Print) vn, State, Zip Code) Brown 2 21213 Ave Balto, md Ford pe 20e_METHOD OF DISPOSITION

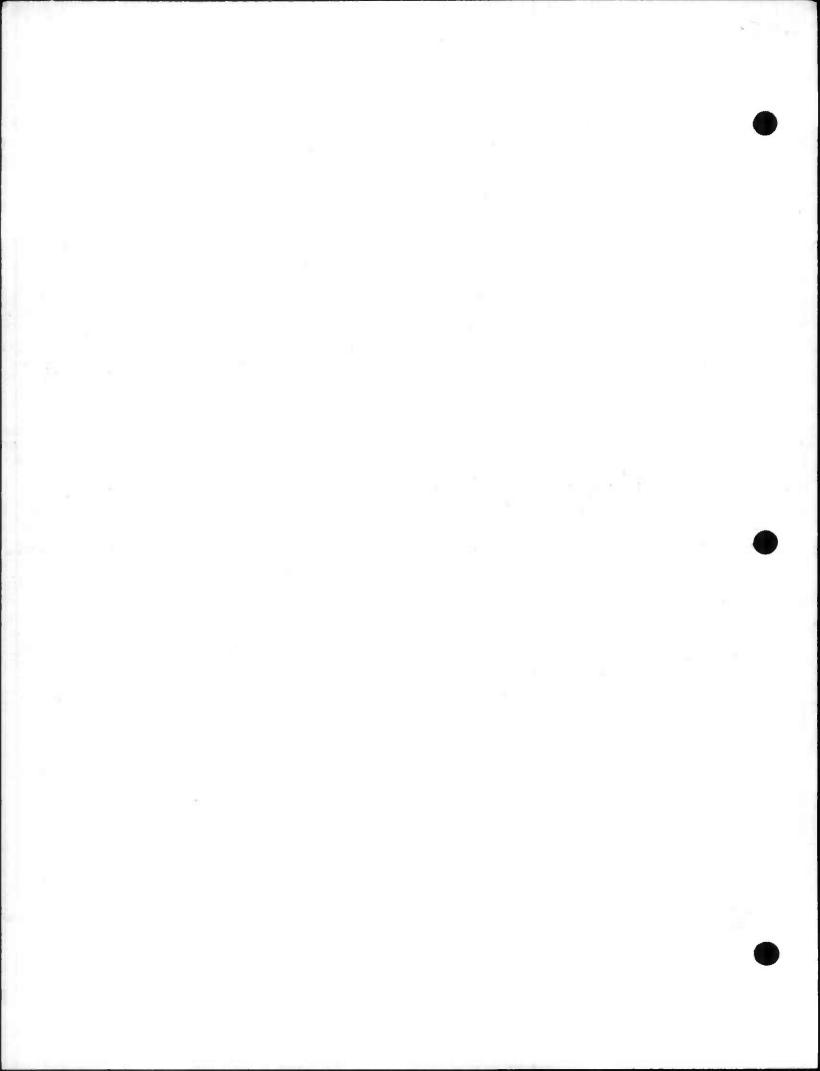
1 A Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name 20c. LQCATION - City or Town, State must SATE mol 5 Other (Specify) aure examiner 22. NAME AND ADDRESS OF FACILITY - Wes FH filled in by the fion, or removal. 23. PART I Enter the chasses, or complications that/ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart failure. List only one cause on each line. 00 medicai Approximete intervai Between cremation, or **IMMEDIATE CAUSE (Final Onset and Death** other traumatic event, the disease or condition Infiltrating Carcinoma of Osophagus
DUE TO LOR AS A CONSEQUENCE OF): completely 4 day by resulting in death) executed with burial, Bilahal Premonia CERTIFICATION certificate has been signed by the attending physician and n the State Dept. of Health and Mental Hygiene prior to bur Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING the death certificate be Dysphafia.

DUE TO (ON AS A CONSEQUENCE OF) CAUSE (Disease or injury that initiated events resulting in death) LAST 0 Injury. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS that doug AVAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO requires t 23 shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: W. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The Item HOSPITAL: OTHER: 1 TYES 2 NO ATTENDING PHYSICIAN: 1 ☑ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 L DIRECTOR: After this cer hours after death with the item 28 is marked, o 27. MANNER OF DEATH 28e. DATE OF INJURY with to 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 SA Natural 1 YES 2 NO BY 2 Accident investigation 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my know HOSPITAL OR TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 ho 2 MEDICAL EXAMINER: On the beele ion, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE (PG4I AS 2441614-31 Culati 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

(PGYI) DEPT. OF INTERNAL MEDICINE HARBOR HOSPITAL

32. DEGISTRAR'S SIMIATURE

BALTIM



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.
N	1. DECEDENT'S NAME (First, Middle, Lest) FRANK COLLINS 2. Date of OEATH OCTOBER DAY 0 1995 01:42 A M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 14 M 2 D F 27 YRS. MONTHS DAYS HOURS MIN. June 13, 1968 Country) Md
oc	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF PEATH
CTO	400 BLK SWANN AVE BALTIMORE
DIRECTOR	106. STATE 106. CITY, TD(A)OR LOCATION 106. CITY LIMITS? 1 YES 2 NO
FUNERAL	106. STREET AND NUMBER 41.1 G OLD Frederick Rd 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 41.1 G OLD Frederick Rd 121229 109. CITIZEN OF WHAT COUNTRY?
FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. TRMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 16. RACE — American Indian, 17. New Maximum Maximum, Puerto Rican, stc.) 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. New Maximum Maximum, Puerto Rican, stc.)
D BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify
COMPLETED	15. DECEDENT'S EDUCATION (Specifly only highest grade completed) Elementary/Secondary (0-12) College (1-4, or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do, NOT use retired.)
MPL	12 EATHER'S NAME (First, Middle, Last)
BE CC	Sheman Duncan Clemintine Flowers
TO B	Shirely Duncan 7221 Kenebunk Ra Bato, 21214
	20s. METHOD OF DISPOSITION Date Committee 20b. PLACE AND DATE OF DISPOSITION (Name of September of Committee Committe
	21. SIGNAMIA OF FUNERAL SERVICE LICENSED 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY
	Dunes D. Scott 4300 Wabash Ave
	23. PARTIL Enter the Names, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or their failure. List only one cause on each line. [MAMEDIATE CAUSE (Size)
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Onset and Death Onset and Death Onset and Death
NO.	Sequentially list conditions, If any, leeding to immediate
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury
ERTI	that initiated events resulting in death) LAST d.
AL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO
	1 (FYES 2 NO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
ICIA	28. PLACE OF DEATH (Check only one) EXAMINER? X YES 2 NO 1 Inpettant 2 ER/Outpettant 3 DOA 4 Number 5 Residence & [YOther (Specify)] SCENE
ЖНс	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) (Month, Da
В	1 Naturel 5 Pending 10-10-95 01-35 M 1 YES 2 NO Subject Shot
TED	3 Suicide Suic
COMPLET	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
B	296. SIGNATURE AND TITLS OF CERTIFIER 296. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Day, Year) OCTOBER 10 1995
은	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Navid R Fowler 111 Penn Street, Baltimore, Maryland 21201
	OCT 1 7 1995 July (Month, Day, Year) 32. REGISTRAR'S SIGNATURE OLUMBER REALER

FOR

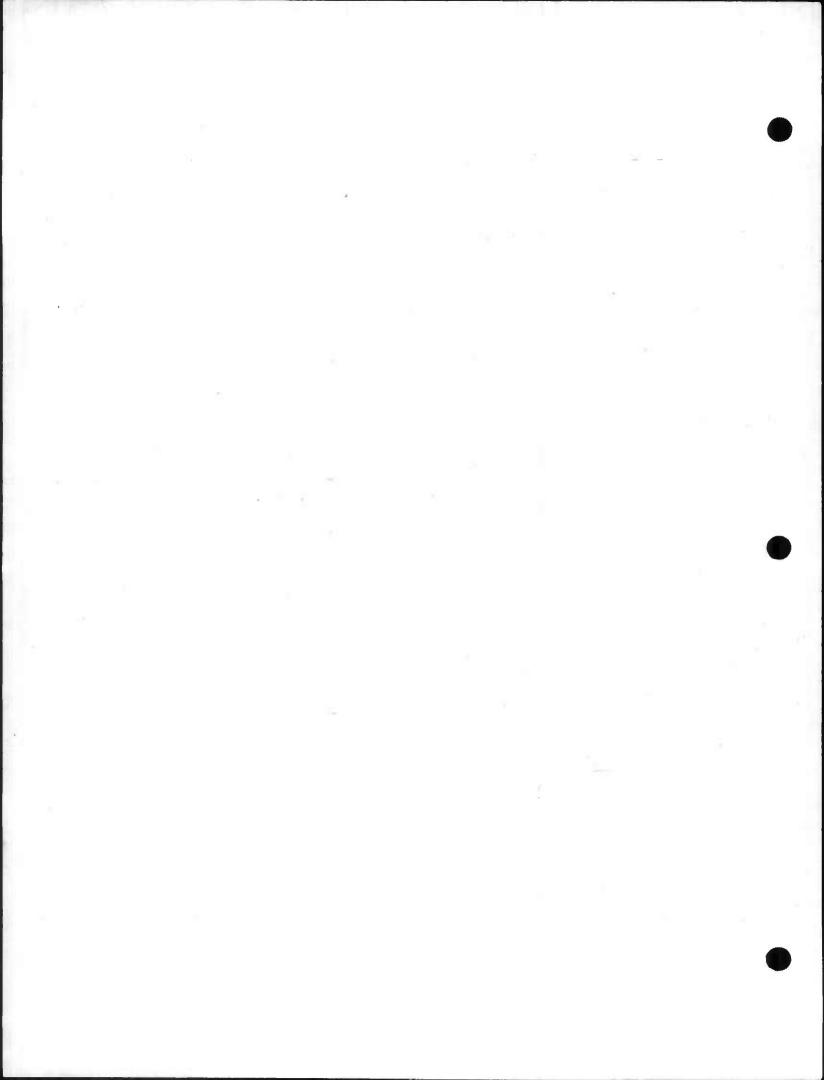
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - REGISTRAR		C	ERTIF	ICATE OF	DEATH	REG	. NO.					
i	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA		3.	TIME OF DEATH			
	LUTHER	ROBIN	CAI	RPEN	TER		OCT .	12.199	YEAR 5	18:54			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In:	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	н	8. BIRTHPLA	CE (State or Foreig			
	215-40-9475	1X M 2 🗆 F	54	YRS.	MONTHS DAYS	HOURS MIN.		26,1941		yland			
œ	9a. FACILITY NAME (If not institution, give s				BALTI	OR LOCATION OF DE		9c. COUN	ITY OF DEAT	Н			
CTOR	HOPKINS BAYVIE	WER			ity		N/A						
DIREC	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWH OR LOCA	ATION			10-	d. INSIDE CITY LIMITS?			
		Baltimor	2				Dundalk			YES 2 X NO			
RA	104. STREET AND NUMBER				10	of. ZIP CODE			ZEN OF WHA				
FUNER	3209 McShaneway	12. WAS DECEDENT	EVER IN U.S. AV	2450		21222				States			
BY FU	1X Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1.	YES 2 1	no Vietn	If yea, s	CENDENT OF HISPAI pecify Cuban, Maxica S 2 X NO Specif	n, Puerto Ricen, at		14. RACE — Black, W Specify:	American Indian, hite, etc. White			
	15. DECEDENT'S EDU	I CATION	1		USUAL OCCUPATI	ION	165 KIND C	F BUSINESS/IND	HETEV	writte			
ETE	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	(C	Give kind of a	work done during m	ost of working	TOD. KIND C	T BUSINESS/IND	OSTAV				
	ciementary/secondary (0-12)	2 Ye		Ма	intenan	CO	St	eel Ind	ustru				
COMPL	17. FATHER'S NAME (First, Middle, Last)			, 10		7	ME (First, Middle, M			27			
w	Hubert Earle Car	rpenter				Margo	ret H.	Davis					
TO B	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street	and Number or Rural			Code)				
F	Lea Carr			7505	Iroquo.	is Avenue	2 Balti	more, M	arylas	nd 212			
	20s. METHOD OF DISPOSITION	noval from State			OF DISPOSITION (Nother place)			c. LOCATION —					
	4 ☐ Donation 5 ☐ Other (Specify)	Abutes .	Oak	Lawn	Cemeter	y 10/17,	195	Baltim	ore, 1	Marylan			
- 1	A redon	E /s	12		Duda	wise Au	ieral Ho	me of D	undall	z, Inc.			
į	23, PART t. Enter the thousand or shock, or shock, or shock the shock to the shock that the shoc	emplications that List only one cause	caused the de se on each line	eath. Do i e.	not entar the m	ode of dying, auc	h as cardiac or	reapiratory arr	eat,	Approximat Interval Bet Onset and			
	IMMEDIATE CAUSE (Fine) disease or condition resulting in death)	The second secon				OCARDIAL F	IBROSIS			Ollset alle			
		DUE TO	OR AS A CONSE	OUENCE O	F):								
RTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
S	If any, leading to immediate cause. Enter UNDERLYING												
Ē	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSE	OUENCE O	F):								
CERI	resulting in death) LAST												
	PART II. Other algnificant condition	na contributing to	deeth but not	reaulting	In the underlylr	ng ceuse given in		AS AN AUTOPSY ERFORMED?		RE AUTOPSY FINI			
DICAL								ES 2 NO	CC	MPLETION OF CA			
ME						,				YES 2 N			
ä	DID TOBACCO USE CONT	RIBUTE TO CA					N 🗆						
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLA	CE OF DEA	TH (Check only one OTHER:)							
IYS	15 YES 2 NO	1 Inpatient 2 X		_	4 Nursing Ho	me 5 🗆 Realdenca							
PHY	27. MANNER OF DEATH 1 XX Natural 5 Pending	28a. DATE OF (Month, De		28b. Till IN.	JURY W	JURY AT PORK? YES 2 NO	28d. DEŞCRIBE	NOW INJURY OC	CURED				
B	2 Accident Investigation	28e. PLACE O	F INJURY — At h	oma, farm			28t. LOCATION /	Street and Number	or Rural Rout	e Number			
_ #	3 Suicida 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28t. LOCATION (Street and Number or Ru City or Town, State)												
TED	29a. CERTIFIER (CERTIFYING BAYESTAN To the heat of an invalidation of the last of the												
m I	(Check only			(one)									
COMPLETE	(Check only one) 2 MEDICAL EXAMINE	ER: On the basis of an		Investigation	on, in my opinion,								
COMPLETE	(Check only	ER: On the basis of an		Investigation	on, in my opinion,	29c. LICENSE NU	MBER	29d. DAT	E SIGNED (M	onth, Day, Year)			
ш	(Check only one) 2 MEDICAL EXAMINE 296. SCHOOL AND TITLE OF CERTIFIES	ER: On the basis of an	amination and/or				MBER	29d. DAT	E SIGNED (M				
BE COMPLETE	(Check only one) 2 MEDICAL EXAMINE	ER: On the basis of an	amination and/or	ЕМ 27) (Туре	s, Print)	29c. LICENSE NU	MBER ME	29d. DAT	E SIGNED (M	, 1995			

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		1 - FOR STATE REGISTRAR	STATE OF MARYL			F HEALTH AND	MENT	AL HYGIEN	E			
		1. DECEDENT'S NAME (First, Middle, L.	nst)				2. DAT	TE OF DEATH	W.	YEAR 3.	TIME OF DEATH	
		WILLIA 4. SOCIAL SECURITY NUMBER	T	COLLIN.	S				16,1		1:34P	
		229-03-4890		(In yrs. lest birthday) 82 YRS.	MONTHS D	EAR F UNDER 24 HRS	(Mo	E OF BIRTH onth, Day, Year)		Country)	ACE (State or Foreign	
should		9a. FACILITY NAME (If not institution, g		OZ THS.	Ab CITY TO	WN OR LOCATION OF		rch 26,				
1, 2, 3 sh	DIRECTOR	GREATER BALT.	IMORE MEDICA	L CENT		OWSON	DEATH			LTIM		
Sable	REC	10e. STATE 10b. CO	UNTY	10c. Cr1	Y, TOWN OR L	OCATION				d. INSIDE CITY		
permit. Pages			altimore		Reist	erstown				1	LIMITS?	
1St	FUNERAL	100. STREET AND NUMBER 11707 Re	isterstown Rd.			101. ZIP CODE 21136					S.A.	
21215-0020 al or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	If yo	DECENDENT OF HISP a, specify Cuben, Mex YES 2 NO Spe	Ican, Puert	an, Puerto Rican, atc.)			American Indien, Thite, atc.	
r attend use as	ETED	15. DECEDENT'S (Specify only highest g		16e. DECEDENT'S			1	56. KIND OF BUS	INESS/INDU			
21 For u	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Excav	se retired.)	ng most of working		Trace	cavat	i = -		
AND. the hospits detached	COMPL	17. FATHER'S NAME (First, Middle, Last)		Excav	ator	10 MOTHERIO	HARE (Elect	, Middle, Melden S		Tug		
A Company		Benjamin L						e Mae W	,			
MARYLAND retained by the hospit should be detached notified at once.	TO BE	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Nown, Stelle, Zip Code) 2590 Bollinger Mill Rd., Finksburg, Md. 2									84018	
may be or, page		204, METHOD OF DISPOSITION	206	. PLACE AND DATE	OF DISPOSITIO	N (Name of	D/	TF 20c, LOC	CATION — CH	ty or Town	State	
AOR pe 6 ma rector, p		1 XBurial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	lemoval from State cem	retery, cremetory or of Evergree	n Mem.	Gardens	Oct.	18,1995	Fink	sburg	, Md.	
BALTIMORE, ter death. Page 6 may be the funeral director, page yval. si examiner must be		21. SIGNATURE OF THEMAL SERVICE	liliant		22. HAN	khardt Fu	FACILITY INETA	1 Chape	1		21117 Mills, Md.	
E PE at		23. PART i. Enter the dissases,	or complications that caused ire. List only one cause on e	d the death. Do	not snter the	mode of dying, sa	ich aa ce	rdiec or respir	atory arres	st,	Approximata	
filled in on, or re		IMMEDIATE CAUSE (Final							-		Onset and Death	
t, t		disease or condition resulting in death)	PSCUI						56	2 4	1 hour.	
			DUE TO (OR AS A	CONSEQUENCE O	F):							
X 8 CBE	101	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS A	CONSEQUENCE O	F):							
m # &	ICA	cause. Enter UNDERLYING CAUSE (Disease or injury	C							BP .		
DS, P.O. B the death certificate the attending phys i Mental Hygiene print, or other	RTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):							
S, P death e atten fental H	CE	DARK II Only a landing	_ d									
A and at I	CAL	PART II. Other significent conditions		ut not resulting	In the under	lying ceuse given i	in Part I.	24a. WAS AN A PERFORE			RE AUTOPSY FINDINGS VILABLE PRIOR TO	
CO ires th signed fealth	MEDIC	Tuberer						1 TYES	100	OF	MPLETION OF CAUSE DEATH?	
w requires the been signed pt. of Health 3 shows an		DID TOBACCO USE CON		E DEATH YE	S D NO	UNCERTA	INI C			1 [YES 2 NO	
De las	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			114					
VITA SIAN: The ortificate h he State f or item	SIC	EXAMINER?	HOSPITAL:	patient 3 DOA	OTHER:	Home 5 - Residence	6 🗆 Ott	ner (Specify)				
	PHY	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c	. INJURY AT WORK?	28d. DI	EŞCRIBE HOW IN	JURY OCCU	RED		
Z 2 2 2 2	B⊀	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO						
TTEN TTEN TOR: after	ETED	3 Suicide 6 Could not datermined		— At home, farm, : 消y)	street, factory,	office		CATION (Street ar y or Town, Stete)	id Number or	Rural Route	Number,	
Z Z Z =	OMPLE		IYSICIAN: To the best of my knowledge. INER: On the bests of examination									
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	O	296. DIGNATURE AND TITLE OF CERTI			an, an my opinio			te ena piece, ena				
TO THE HOSPIT TO THE FUNER De filed within 7	BE	Jus Coun	Q 100			29c. LICENSE N			Z9d. DATE S	O I I	orth, Day, Year)	
FFAS	2	36. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEA						/ .	1.,,	, ,	
10		JAMES QUINI		7801 40,	ruc K	D. 70	WSOL	, m)	21.	204		
		"OCT 1"7"1995"	Talia HESTIPAR TIGH	44								

permit. Pages 1, 2, 3 should

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours afer death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacthed for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

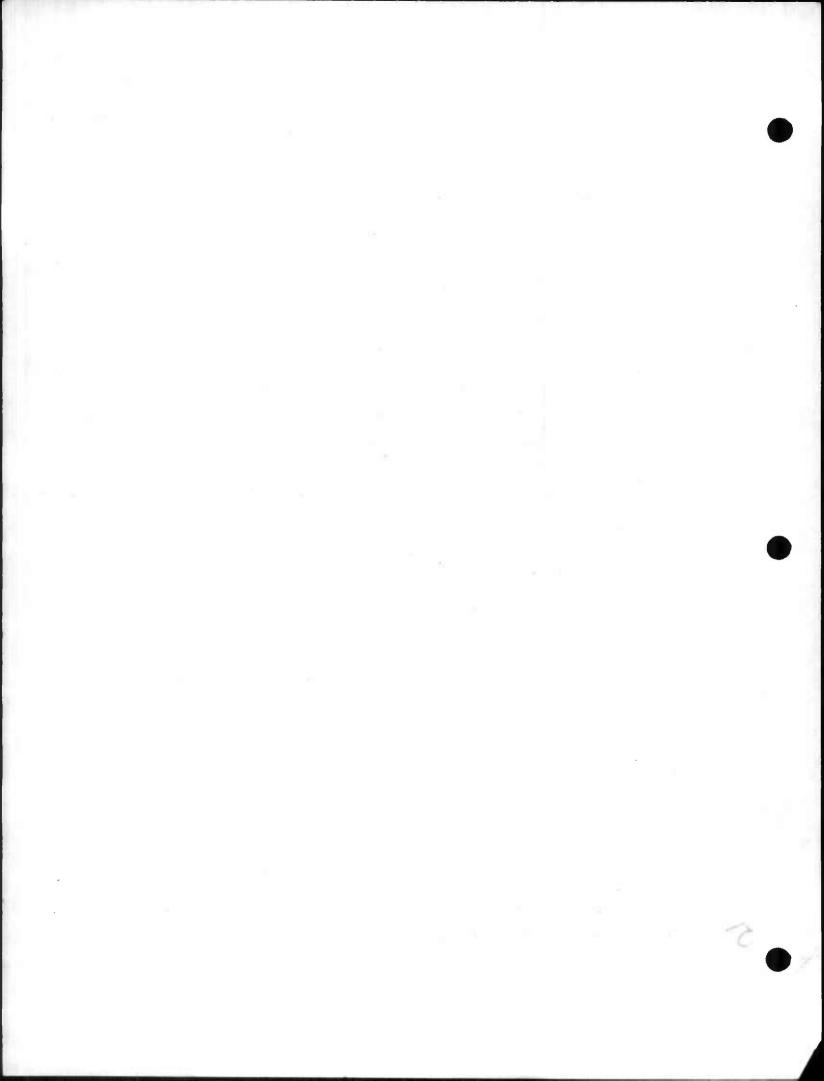
223

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 10 600 TAMELIA Denise 10 CROMWELL 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, New IF UNDER 24 HRS. DAYS 1 - M 2 00 F 37 March 26. 1958 220-80-9576 Maryland the FACILITY HAME (If not imittuillon. 96. CITY, TOWN OR LOCATION OF DEATH Re. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore Monkton 1 - YES 2 X NO FUNERAL 10s. STREET AND NUMBER tor. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3711 Hess Road 21111 USA 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, apacity Cubon, Mesican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 14. RACE -- American Indian. Black, White, etc. If yes, specify Cubon, Mexican, Pu 1 — YES 2 X NO Specify: 1 X Never Married 2 Married Specify: B **Black** 3 Widowed 4 Divorced COMPLETED 18. DECEDENT'S EDUCATION His. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done like Do NOT use relined.) Elementary/Secondary (9-12) College (1-4 or 5+) 12 n/a Care-giver Health Care 17. FATHER'S MAME (First, Middle, Leaf) 18. MOTHER'S NAME (First Middle Martin Surrame) Elwood Olivia Mosby Horace Cromwell BE The INFORMANT'S NAME (SpecPrint) 19b. MAILING ADDRESS (Street and Number or Rural Route Number: City or Town, State, Zip Code) 2 5661 Purdue Ave., apt C, Baltimore, MD 21239 Olivia Cromwell 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 70s. LOCATION - City or Town, State 20. METHOD OF DISPOSITION
1 Durial 2 Committee: 2 Permoval 4 Donation 7) Other (Specify)
21. SIGNATURE OF TRIBETAL STRVICE LICENSE

Bryan W. Clary QALE Catonsville, MD Metro Crematory 22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 23. PART I. Enter the diseases, or complications that caus shoot, or heart failure. List only one gause on of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death IMMEDIATE CAUSE (FINAL disease or condition resulting in death) SEQUENCE OF orace CERTIFICATION Sequentially list conditions, A CONSEQUENCE OF: If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST PART II. Other significant conditions pontributing to geath but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF GAUSE 24s. WAS AN AUTOPSY MEDICAL PERFORMEN T VES 2 W NO OF DEATH? T TES 2 HO YES | NO | UNCERTAIN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: FLACE OF DEATH /Chuck only o 25. WAS CASE SEPERRIED TO MEDICAL EXAMINER? HOSPITAL: OTHER: 1 | Inpetient 2 | ER/Outpetie # ET DOA 27. MANNER OF BEATH 28a. DATE OF INJURY (Month, Day, Reet) 28c. INJURY AT WORK? 384. DESCRIBE HOW INJURY OCCURED 1 E HIRLING 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJUSTY - At home, farm, street, fectory, office 3 D Suicide 28f. LOCATION (Street and Number or Flural Route Number City or Teen, State) 6 Could not be determined COMPLETED 29a. CERTIFIER 1 CERTIFYING PHYSICIAN; To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMPLER: On the basis of examination and/or investigation in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 00 296. SIGNATUME AND TITLE OF CERTIFIES LICENSE NUMBER BE uci 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) イノスノス

MellMI

AEGISTRAR'S



CERTIFICATE OF DEATH

REG. NO.

DAY

3. TIME OF DEATH

6:00

8. BIRTHPLACE (State or Foreign

W. Baltimore Street

Approximate interval Between **Onset and Death** Many years

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

PM

2. DATE OF DEATH

September

FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

Chel

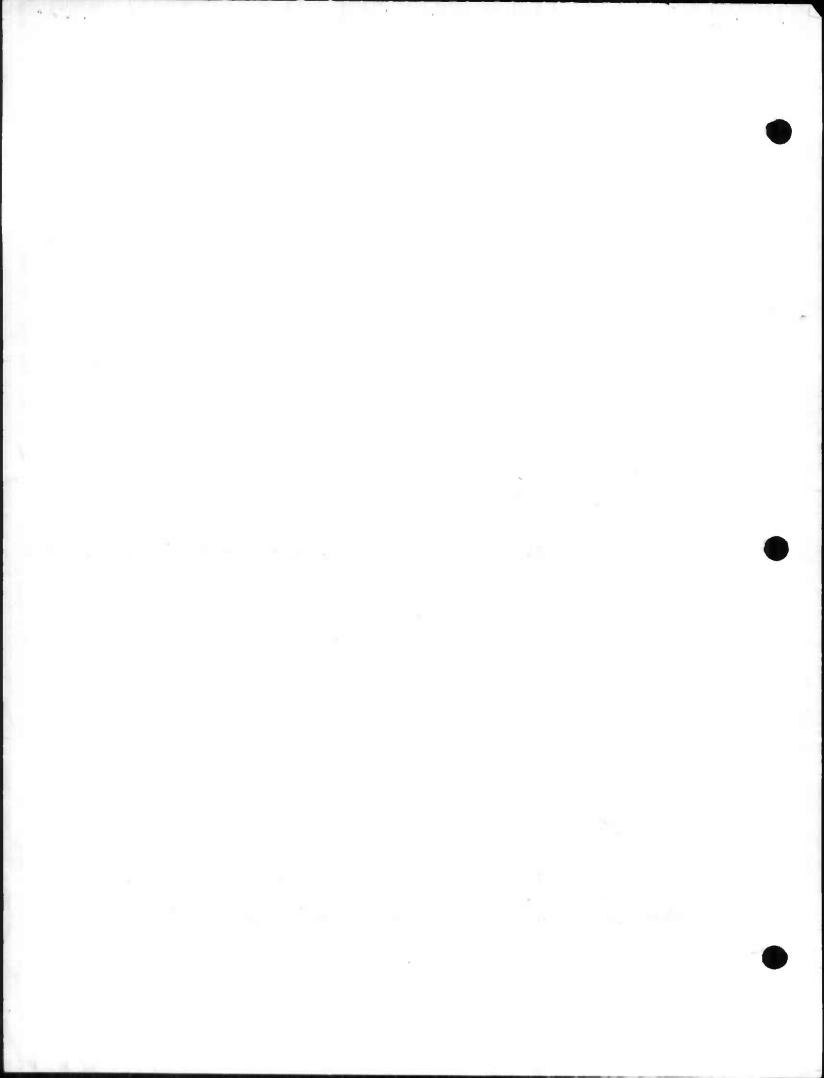
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1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	016 21 6070	PER	J. SEA	a. AGE (III yrs. I		MONTHS	DAYS	HOURS	MIN.	(Month, L			Country)	LACE (State or Poreign
	218-36-8072		1 🗌 M 2 🗶 F	92	YRS.					Dec.	04.	1902		uland
	e. FACILITY NAME (If not in							OR LOCATI	ON OF OE	ATH		9c. COU	NTY OF DEA	йн
CTOR	St. Agnes H		Ba	ltin	nore					Balt	imore			
5 -	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c						OR LOCA	71011						
OF I	Maryland		imore			Caton								LIMITS?
4	100. STREET AND NUMBER						10	. ZIP COD						AT COUNTRY?
FUNERAL	3 Dutton Av	enue						2122	? 8				u.s.A	•
. 8	It. MARITAL STATUS 1 Never Married 2 Never Married 3 Never Married 3 Never Married 2 Never Married 3 Never Ma		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	NO		If yee, sp	ENDENT Code of the	ın, Maxica	IIC ORIGIN? (n, Puerto Ric /:	(Specify Ya an, atc.)	a or No—		- American Indian, White, atc. White
	ts. OEC (Specify on	EDENT'S EDU	CATION completed)	16a. I	DECEDENT'S	S USUAL C	CCUPATE during me	ON ost of working	na	18b. K	IND OF BU	ISINESS/INC	DUSTRY	
	Elementary/Secondary (College (1-4 or 5		ite. Do NOT i	use retired.)								
L	12		4		Tea	ache	r				Educ	atio	n	179
- NO.	17. FATHER'S NAME (First, A	fiddle, Last)						16. MOT	HER'S NA	ME (First, Mic	idle, Meider	Sumame)		
ш	Edward John	Chell						Ca	ther	ine E.	lizal	beth i	Doll	
\sim \sim	19a, INFORMANT'S NAME ((sister)		19b. MAILIN	O ADDRES	S (Street a	and Numbe	r or Rural	Route Number	City or Tox	wn, State, Zip	Code)	
	Thelma McNe	mar			3 Du	tton	Aue	nue-	Cato	nsvil	le, 1	Maryle	and	21228
	20a. METHOD OF DISPOSIT 1 Durial 2 Cremation 4 Donation 5 D Other	TION on 3 🗆 Ram	oval from State		E AND DATE cremetory or	OF DISPO	SITION (N			OATE	1		City or Town	n, State
	H. SHGMATUBE OF FUNERA	AL SERVICE LIC	CENSEERonal		Dir.	3	tate		tomy	Boar				more Stre 01-1559
CERTIFICATION	IMMEDIATE CAUSE (Fi disesse or condition resulting in death) Sequentially list condi- if sm, leading to imme- cause. Enter UNDERLY CAUSE (Disesse or inje	tiona, ediate	b	OR AS A CONS	SEOUENCE (OF):	eroti	د (د	oibre	Vascu	lar	diseo	se	Mony yeo
CENT	that initieted eventa resulting in deeth) LAS		d											
MEDICAL	PART II. Other significa	ant condition	ns contributing to	o death but no	t resulting	in the u	nderlyin	ig ceuse	given in			N AUTOPSY PRMED?	0	WERE AUTOPSY FINDIN MAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? I YES 2
	DID TOBACCO U	JSE CONT	RIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆	NO [UNC	CERTAI	N 🗆				
ICIAN:	25. WAS CASE REFERRED TEXAMINER?	TO MEDICAL		26. PL	ACE OF DE)						
δ I	1 TYES 2 THO		HOSPITAL:	☐ ER/Outpatlant	3 🗆 DOA	4 Nu		ne 6 🗆 R	lesidenca	6 Other	(Specify)			
<u>-</u>		Pending Investigation	28a. OATE Of (Month, I	F INJURY Day, Year)	28b. Ti	ME OF JURY M	28c. IN W	JURY AT ORK? YES 2	□ NO	28d. DESC	RIBE HOW	INJURY OC	CURED	Za III.
TED BY	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. PLACE (building	OF INJURY — At , atc. (Specify)	home, farm	, atreet, fee	ctory, offi	ca		281. LOCAT City or	TON (Street Town, State	t and Numbe	r or Rural Ro	oute Number,
COMPLET	cool only		ER: On the beals of											and manner as stated
8	296 SIGNATURE AND TITL	E OF CERTURE	fluen	, W	$\overline{}$			29c. LIC	ENSE NU	MBER 13		29d. DAT	toner	Month, Day, Year)
유	30 NAME AND AGORES		1 1									40	1-2-4	1 4 4 4 6

32. REGISTRAR'S SIGNATURE



ITEM: 16a, PER INFORMANT FILM G-729 11/28/95 t.t

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

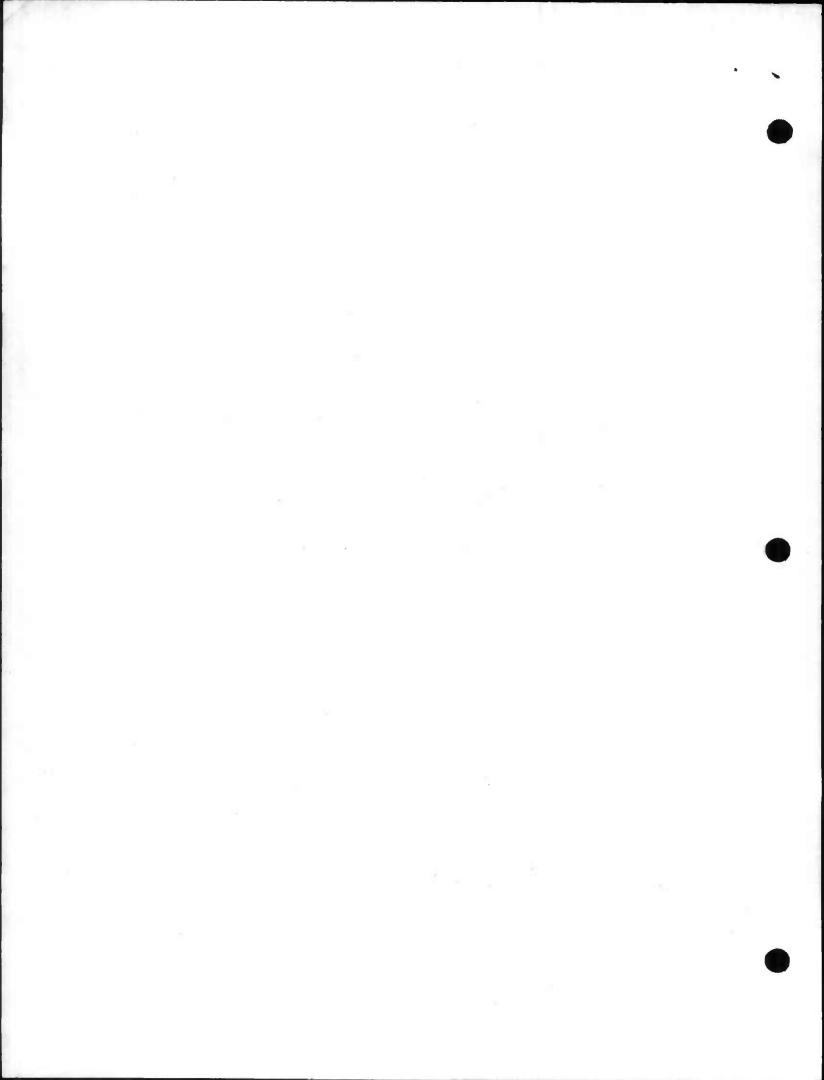
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTHAR		CEH	HEIC/	ALE OI	DEATH	REG. N	Ю		
	1. OECEDENT'S NAME (First, Middle, Last) JACQUES	A	RNOLD		C	LERMONT	2. DATE OF DEATH MONTH OCTOBE!	DAY	YEAR	ME OF DEATH
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. last birt	MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	2 DATE OF BIRTH		8. BIRTHPLACE	E (State or Foreign
	372-58-7844	1 X M 2 □ F	56	ras.			NOV. 2,			aiti
~	9a. FACILITY NAME (If not institution, give st					OR LOCATION OF D	EATH		UNTY OF DEATH	
ğ	PRINCE GEORGES	S HOSPIT	AL CENT	ER	Crie	verly		PI	RINCE (GEORGES
E I	10a. STATE 10b. COUNTY	-	30	C. CITY, TO	WN OR LOC	ATION			10d.	INSIDE CITY
- DIRECTOR	MD Howa:	rd	_	Gle	nelg				1 🗆	YES 2 NO
FUNERAL	14221 Day Farm 1	Road			1	21737		10g. C	USA	COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		EVER IN U.S. ARMED YES 2 X NO R OR DATES		If yes,		NIC ORIGIN? (Specify an, Puerto Rican, etc.) y:	Yes or No-	Black, White	nerican Indian, a, atc. aitian
COMPLETED	15. DECEDENT'S EDUC		16a. DECED	ENT'S USU	AL OCCUPA	TION	16b. KIND OF	BUSINESS/II		
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	NOT use ret	ired.)	nost of working				
릴	12	5+	-Psycl	nolog	ist p	SYCHIATRIST	Healt	n Fie	ld	
Š	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Middle, Maid	len Sumame)		
BEC	Andre Clermon	t				Germain	ne Desir			
	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or		Zip Code)	
2	Renee M. Clermont	(Spouse	142	221 D	ay Fa	rm Road,	Glenelg,	MD	21737	
	20e. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Remo	oval from State	20b. PLACE AND cemetery, cremate Crestla			Name of Oct			ctsville	
	21. SIGNATURE OF FUHERAL SERVICE LIC		- /	WIII	22. NAME	AND ADDRESS OF FA	CILITY			
	*K.Ca	. Wit	to I				sell C Wi			
	23. PART I. Enter the disesses, or cahock, or heart failure. I	omplications that List only one caus	e on each line.						irreat,	Approximate interval Between Onset and Death
	disease or condition resulting in death)	DUE TO	DR AS A CONSEQUE	NCE OF):	X	leck I	zjune	4		
TION	if any, leading to immediate	b. DUE TO (6	OR AS A CONSEQUE	NCE OF):						
CERTIFICATION	CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (6	OR AS A CONSEQUE	NCE OF):						
		d.								
EDICAL	PART ii. Other algnificent condition	a contributing to d	leeth but not resu	iting in th	ne underly	ing ceuse given in	PERI	AN AUTOPS ORMED?	AVAIL CDMI	AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE
ᇤᅵ								2 140		YES 2 NO
Σ	DID TOBACCO USE CONTI	RIBLITE TO CAL	ISE OF DEATH	YES	□ NO I	UNCERTAI	N '		74	150 1 110
¥	25. WAS CASE REFERRED TO MEDICAL	TO THE	26. PLACE O					_		
200	EXAMINER?	HOSPITAL:	ER/Outpetient 3 🗆		HER:		A D du an an an			
PHYSICIAN:	27. MANNER OF DEATN	26a. DATE OF I		Bb. TIME OF	_	ome 5 Residence	264 DESCRIBE HO	W INJURY C	CCURED	
	1 Netural 5 Pending	(Month, Day		INJURY	\	YES 2 NO	Delais.	3.14	+	, No. of
B	2 Accident Investigation Suicide & Could not be	28a. PLACE OF	INJURY — At home.	term, etree	t, tactory, of		261 LOCATION (Sim	et and Numi	per or Rural Route I	Yumber >
	4 Nomicide 6 Could not be	building, a	tc. (Specify)	27	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					175+198)
	29a. CERTIFIER		017-0	01			MC. 70			10 11 10
COMPLETED	only t CERTIFYING PNYSI 2 MEDICAL EXAMINE						to the cause(a) and time, data and place			manner as stated.
	299 SIGNATURE AND TITLE OF CERTIFIES	. /				29c. LICENSE NU	MBER	29d. D.	ATE SIGNED (Mont	h, Day, Year)
TO BE	Jain	hefe	M)			O.C.M.	.E.	DC	TOBER	11 1995
-	30, MAME AND ADDRESS OF PERSON WN	COMPLETED CAUSI	E OF DEATH (ITEM 21	n) (Type, Prin 1 Pe	nn S	treet, I	Baltimor	e, M	arylan	d 21201
	OCT 1 7 1995	a distra	S FULLEY			-				



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31. DATE FILED (Month, Day, Year)

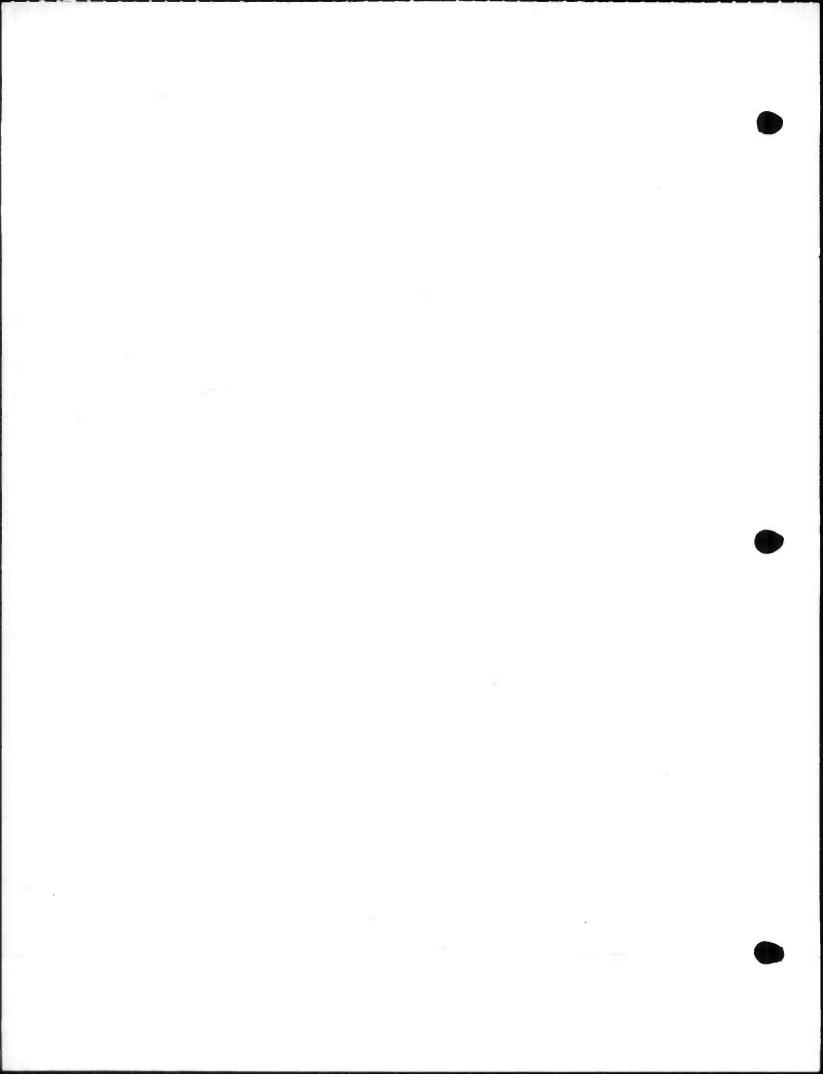
OCT 1 7 1995

July Mudlar Madell

YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of attending physician.	g physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	rth the State Dept. of Health and Mental Hygiese prior to burial, cremation, or removal.	ther traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF M					EALTH AI		ENTAL HYGIENI REG. NO.	E		
	1. OECEOENT'S NAME (First, Middle, Last)								2. DATE OF OEATH MONTH DA	Y	YEAR	3. TIME OF GEATN
	RAYMOND CORNI	ELIUS		CO	LE				OCTOBER 1	4, 1	995 ^R	12:15 AM M
	1 1 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1		6. AGE (In yrs. la	st birthday)	IF UNDER	1 YEAR	IF UNDER 24	MIN	7. DATE OF BIRTH (Month, Day, Ybar)		8. BIRTI Count	HPLACE (State or Foreign
	215-01-2518	X M 2 F	76	YRS.	MONTHS	UNIO	HOURS		08-7-1919		MAR	YLAND
	9a. FACILITY NAME (If not institution, give stree						R LOCATION		IN	117.00	NTY OF C	
O.	504 STANHOME DRIVE	€			(GLEN	BURNI	LE		AN.	NE A	RUNDEL
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			I soc CIT	Y. TOWN C	OR LOCAT	ION					10d. INSIDE CITY
<u>E</u>		ANNE ARU	NDEL	100011	.,		URNIE					LIMITS?
	10a. STREET AND NUMBER						ZIP CODE			40- 017	TEN OF I	1 YES 2X NO
FUNERAL	504 STANHOME DRIV	F.				101		061		iog. Cit		S.A.
뿐		2. WAS OECEOENT	FVFD IN II C. A.	DIMEO	Lan	10000						
3	1 Never Married 2 Married	FORCES? ty	YES 2	NO		If yea, spe	ecify Cuben, A	Maxican,	ORIGIN? (Specify Yea Puerto Rican, etc.)	or No-		E — American Indian, k, White, atc.
ВҰ	3 X Widowed 4 Divorced	WW II	AR OR OATES			1 YES	2 X) NO	Specify:			Spec	WHITE
0	15. DECEOENT'S EQUCAT		16a. O	ECEOENT'S	USUAL O	CCUPATIO)N		16b. KINO OF BUS	INESS/IN	OUSTRY	
1	(Specify only highest grade co. Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 +)	life.	Bive kind of a Do NOT u	work done i se retired.)	during mo	st of working					
PL	12	NONE		ECTRI	CAL	TECH	NICIA	N	WESTI	NGHO	USE	
COMPLET	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER	R'S NAMI	E (First, Middle, Maiden	Sumame)		
	WILLIAM		COLE				MAR	Y		CO	RNEL	IUS
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street a	nd Number or	Rural Ro	ute Number, City or Town	n. State, Zi	o Code)	MD. 21060
5	BEVERLY M. RICHAR	DS		117	SOUT	н је	ROME I	PARK	WAY, GLEN	BUR	NIE,	MD. 21060
	20e METNOD OF DISPOSITION 1 [XBuriel 2] Cremetton 3] Remove	-:	20b. PLACE						DATE 20c. LO	CATION -	City or To	own, Stata
	4 Donation 8 Other (Specify)	il trom State	LOUD(omatory or o	RK C	EMET	ERY		10/17 1995 BAL	TIMO	RE,	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /	,				D AODRESS	OF FACI	- City	ON E	IINFD	AL HOME,
	1 96 × 10	21	1-		1	SECO	ND AV	FMIIF				IE,MD.21061
	22 BART I False the disease	1790	ans									
	23. PART I. Enter the diseases or cor shock, or heert failure. Lit	t only one caus	se on each lin	e.	noi anter	the mo	de or dying	, sucn	as cardiac or respi	ratory at	Teat,	Approximate interval Batween
	IMMEDIATE CAUSE (Final disease or condition	1	0	1	Λ		WI	10	1.	1./	1	Onset and Death
	resulting in death) a.	aruna	my M	Tell	YVIA	Meia	0/	Con	COTUR 1	flore	Tya	rec
		1 f -	OR AS A CONSE	QUENCE O	(F):	/			0			
O	Sequentially list conditions, b.	(MMa	OR AS A CONSE	L. FL	KLW.	y con						
CERTIFICATION	if sny, leading to immediate csuse. Enter UNDERLYING	5/00	H. A. A. CONSE	/ /	7 . /	1	1					
E C	CAUSE (Disease or injury that initiated events	OUE TO	OR AS A CONSE	QUENCE O	if):	my	uc v-c					<u> </u>
	resulting in death) LAST	acrete	4 Ph.		11	4. a .	0 K		und I			1
GE	d.	00000					0					
	PART II. Other significant conditions	contributing to	death but not	resulting	in the ut	nderlyln	g cause giv	en in P	ert i. 24a. WAS AN PERFOR		240	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
5	1/0 Xleep ver	2 Mr	on ho	w/;	- 14	2	5 pas	1	1 YES 2	NO		COMPLETION OF CAUSE OF DEATH?
MEDICAL	Survey BPF	+ 5/1	TUR	. 4	50-	thy	Soude	4-7-				1 YES 2 NO
	DID TOBACCO USE CONTRI	BUTE TO CA	USE OF DEA	ATH Y	ES 🗆 I	NO E	UNCER	RTAIN				
M	25. WAS CASE REFERRED TO MEDICAL		28. PLA	CE OF OEA	TN (Check	only one)						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO SUNCERTAIN S. WAS CASE REFERRED TO MEDICAL 28. PLACE OF GEATN (Check only one) EXAMINER? 1 YES 2 NO 1 Inpettant 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF GEATN 286. OATE OF INJURY (Month, Day, Year) 1. Notice of the control of												
27. MANNER OF CEATN 28a. OATE OF INJURY (Month, Day, Your) 28b. TIME OF 28c. INJURY AT WORK? 10. WORK?												
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Michal, De	ly, rour)		M		YES 2 N	NO				
									Route Number,			
4 Nomicide determined determined												
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the heat of	my knowledge 4	leath occur	rad at the t	time data	and place	nd due to	the cause(s) and mar	mer en ch	ted	
M	(Check only one) 2 MEOICAL EXAMINER:											a) and manner as stated
8						,						
H	296. SIGNATURE AND TITLE OF CENTIFICIT	2,00					29c LICENS		96	29d. DA	IE SIGNEI	Month, Dey, Year)
0	- Marie IXIA	600							14		101	10/45

		1 - FOR STATE OF MARY		RTMENT OF I		MENTAL HYGIEN				
	-	1. DECEDBRY'S NAME (First, Middle, Last)	Jr.			2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH		
10		309-30-9883 1 PM 2 D F	(In yrs. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign ntry)		
2, 3 should	TOR	9a. FACILITY NAME (If not institution, give street and number) RESIDENCE OF DECEDENT		9b. CITY, TOWN	or Location of D		9c. COUNTY OF	timere		
permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY Md. Baltimore		TY, TOWN OR LOCA	TION Esse	ex 10d. INSIDE CITY LIMITS?				
	FUNERAL	100. STREET AND NUMBER 126 Villa Capri Cil	rc1e	10	H. ZIP CODE	1221		1 YES 2 NO WHAT COUNTRY? JSA		
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVE FORCES? 1 Y YES, GIVE WAR OF	R IN U.S. ARMED	CENDENT OF HISPAI pecify Cuban, Mexica S 2 NO Specif	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	CE — American indian, sechy: White, atc.				
- 53	8	(5. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5 +)	18a. DECEDENT'S	USUAL OCCUPATI work done during me se retired.)		16b. KIND OF BUS	SINESS/INDUSTRY	WIII OC		
YLAND 2 by the hospital be detached for at once.	COMPLET	12th 17. FATHER'S NAME (First, Middle, Last)	10	al Wor	18. MOTHER'S NA	ME (First, Middle, Maiden	st Offi Surname)	ce		
MARY retained by 5 should b) BE	Charles O. Carter Si 190. INFORMANT'S NAME (Type/Print)		ADDRESS (Street		ie Grah Route Number, City or Tow	n, State, Zip Code)			
	٩	Rosemarie Carter	12	6 Vill:	a Capri	Circle	Baltimo	ore Md. 212		
BALTIMORE, ser death. Page 6 may be the funeral director, page val.			Mot rock	other plecel		/13/95 B	CATION — City or			
ALTIMOR death. Page 6 ma e funeral director, p ii.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	O.A.	22. NAME A	ND ADDRESS OF FA	CILITY				
BAI after dea by the fur moval.		K. Jerry (on	elly	300 1	Mace Av	neral Ho e. Balti	mroe Mo			
hin 24 hours lely filled in thation, or re-		23. PART I. Enter the diseases, or complications that cause shock, or heart fallure. List only one cause or iMMEDIATE CAUSE (Final disease or condition resulting in death)	CARC	ZINOM	ATOS	5		Approximate interval Between Onset and Daath		
	z		S A CONSEQUENCE O	es: Carun	oma	Adren	al			
De ex cian a for to	ATIO	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	S A CONSEQUENCE O	F):		Adren	ues			
P.O. En certificat inding phy Hygiene is orther	ERTIFICATION	CAUSE (Disease or injury that initiated avents resulting in death) LAST	S A CONSEQUENCE O			0				
() 0 6	AL CE	PART II. Other significant conditions contributing to death			g cause given in	Part i. 24a. WAS AN		Ib. WERE AUTOPSY FINDINGS		
RECORDS w requires that the been signed by the pt. of Health and M shows any inlu	MEDIC	MASSIVE				PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 _ YES 2 _ NO		
AL has the Dept Dept 23	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OF DEATH Y		UNCERTAIL	<u> </u>				
F VITA SICIAN: The certificate h the State in the intermediate in the inte	IYSIC	1 VES 2 NO 1 Inpatiant 2 ER/O			na 5 🗆 Residence					
N O G PHY er this ath with marked	Æ	Natural 5 Pending (Month, Day, Year Investigation		M 1	JURY AT DRK? YES 2 NO	26d. DESCRIBE HOW II				
DIVISIO OR ATTENDIN DIRECTOR: An hours after des item 28 is n	ETED	4 Homicide datermined building, stc. (S	pecify)	street, rectory, orne		281. LOCATION (Street a City or Town, State)	ind Number or Hure	I Houle Number,		
로 글로 =	COMPLETED	29s. CERTIFIER (Check only One) 2 MEDICAL EXAMINED On the basis of examina						e(a) and manner as stated.		
TO THE HOSP! TO THE FUNES be filed within	H	296. SIGNATURE AND TIPLE OF CENTIFIER	ur	\supset	29c. LICENSE NUI	8326	29d. DATE SIGNE	(Month, Day, Year)		
FFD	2	30. NAME AND ADDRESS OF PILE ON WHO COMPLETED CAUSE OF				0000	<u> </u>	10/19/25		
3		Naeem Gauhar 404-406 Ea	stern B	Lvd. Ba	1timore	MD 21	221			
19		OCTA 71995 Juli Studior Ray	tally							

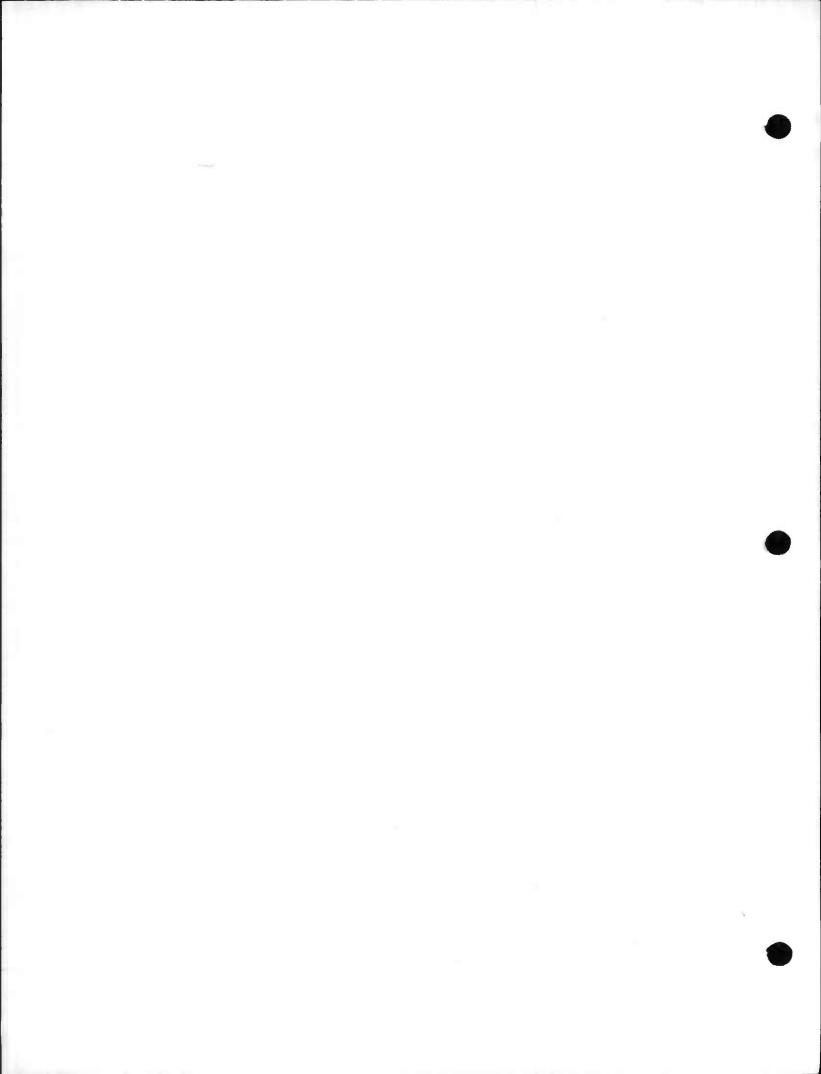


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS

BALTIMORE, MARYLAND 21215-0020	in 24 nours after death. Page 5 may be retained by the hospital or attending physician,	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	, the medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

I	tem#7. G-film 7	28 per STATE OF I	F.H 10 MARYLAND/	/20/ DEPAF	95 P	C F HEALTI	AND	MENTAL H	IYGIEN	E		
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CI	RIII	ICATE (OF DEA	TH		REG. NO.			
	Irene B. (Craft						2. DATE OF MONTH OCt.	13	19	9 ⁷ 5	3. TIME OF DEATN 3:30a M
	4. SOCIAL SECURITY NUMBER 220-22-6537	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YE	AR IF UND	ER 24 HRS.	7. DATE OF (Month, _	26, 20,1	918	8. BIRTN	PLACE (State or Foreign
	90. FACILITY NAME (If not institution, give :	street end number)			9b. CITY. TO	MN OR LOCA	TION OF D		20,1		NTY OF D	
DIRECTOR	17 Riverside	Road				Esse				140.00		imore
EC	10a. STATE 10b. COUNT	Y		10c. CIT	Y. TOWN OR L	OCATION						10d. INSIDE CITY
	Md.	Balti	more			_	Esse	x				LIMITS?
FUNERAL	17 Riverside	e Road				101. ZIP CO		221		_	USA	VHAT COUNTRY?
5	11. MARITAL STATUS		T EVER IN U.S. AR		13. WAS	DECENDENT	OF HISPAI	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced		MAR OR DATES	•0		YES ZX NO		n, Puerto Rica y	n, etc.)		Speci	
		<u> </u>										White
	15. DECEDENT'S EDU (Specify only highest grade	completed)	(G	ive kind of	USUAL OCCU	PATION g most of worl	ing	16b. KIN	D OF BUS	HNESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+}	oo NOT u					Glen	ı L.	Mai	ctin
5	17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NA	ME (First, Middl	le, Maiden :	Sumame)		
BE	John Davis I	Bentley					Ro:	xanne	Ηυ	int		
	190, INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (St	eet end Numb	er or Rural I	Route Number, (City or Town	n, State, Zip	Code)	
임	Millard Craft	Sr,	17	Ri	versi	de Ro	ad :	Balti:	more	Md	. 21	1221
	Millard Craft Sr, 17 Riverside Road Baltimore Md. 21221 20e. METHOD OF DISPOSITION 1 St Burlel 2 Cremetton 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of Campelory, cremetory or other place) Bakers Cemetery KY											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Connelly Funeral Home of Essex 300 Mace Ave. Balitmore Md. 21221											
	23. PART I. Enter the diseases, or	opplications the	it caused the de	ath: Do r	not enter the	mode of d	Ing, auc	h as cardiac	or respir	ratory arr	rest,	Approximata
	shock, or heart adduct. List only one cause on each trie. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. The triangle of the cause of the c											
	resulting in death)	DUE TO	(OR AS A CONSEC	DUENCE O								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	bDUE TO	(OR AS A CONSEC	OUENCE O	F):							
2	cause. Enter UNDERLYING CAUSE (Disease or injury	с										
밥	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
병		d										
_	PART II. Other algnificant condition	a contributing to	death but not r	esulting	n the under	ying cause	given in	Part I. 24e			24b.	WERE AUTOPSY FINDINGS
MEDICA								1.0	PERFORI	1000		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME												OF DEATH?
												120 120 100
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				2	. PLACE OF	DEATN (Ch	eck only one)				
PHYSICIAN	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	Nome 5 📉	lesidence	6 Other (Sp	ecify)			
Ę	27. MANNER OF DEATN	28a. DATE OF (Month, D		28b. TIM		INJURY AT WORK?		28d. DESCRI		JURY OCC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	(Morally D	ay, roury	1140		YES 2	□ NO					
ED B	3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At ho	me, farm, s	street, factory,	office		28f. LOCATIO	N (Street as	nd Number	or Rural A	oute Number,
	4 Nomicide determined		area (Opoony)				_	City or io	wn, State)			
F.	20a. CERTIFIER (Check only	CIAN: To the best of	my knowledge, de	nth occum	ed at the time,	data end plac	e, end dua	to the cause/a) end man	ner as stat	ed.	
COMPLET	2 MEDICAL EXAMINE	R: On the beels of e	xamination and/or i	nvestigatio	n, in my opini	n, death occi	red at the	time, data and	place, and	due to th	e ceuse(a)	and menner as stated.
BE	29b. SIGNATURE AND TITLE OF GERTIFIED	Wall 1	Plenses	de			ENSE NUN			29d. DATI	SIGNED	(Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WN	. 4							00.1	1 3	7//	713
	MILMARC PURIO 1940 EAVIEW AVE BALTIMON MI ZIZZO											
	31. DATE FILED (Month, Day, Year)	J 32. REGISTRA	R'S SIGNATURE					,				
	OCT 1 71995 Jul	Divoler	Reshill									



permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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MPORTANT:

THE FUNERAL (filed within 72 h

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this certificate has been signed by the attending physician and completely filled in by the fun	, cremat	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medic
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH MICHAEL JOHN CAMPBELL OCTOBER 10. 10:00 1995 P.M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) AUGUST 16, IF UNDER I YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig DAYS HOURS MIDITAND, MARYLAND 1XTM2 DE 218-24-8715 1930 9a. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATH 95 CITY TOWN OR LOCATION OF DEATH GLEN ARM BALTIMORE 6204 HUTSCHENREUTER LANE RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYI AND BAI TIMORE GLEN ARM 1 TES 2 NO 10a STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21057 U.S.A. 6204 HUTSCHENREUTER LANE 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 Y YES 2 NO IF YES, GIVE WIR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 XX Married 3 Widowed 4 Divorced WHITE WW TT 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sne Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A CONTRACTOR SFLF-EMPLOYED 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) LAWRENCE WILL TAM CAMPBELL MILDRED LOUISE KEPLINGER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN M. CAMPBELL 6204 HUTSCHENREUTER LANE GLEN ARM, MARYLAND 21057 20s. METHOD OF DISPOSITION
1 □ Burlel 2 [X Cremetion 3 □ Ramoval from State
4 □ Donation 6 □ Other (Specify) _ 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE WETRO CREVATURY COLOR OCTOBER 11, 1995 BALTIMORE, MARYLAND 22. NAME AND ADDRESS OF FACILITY
E.F. LASSAHN FUNERAL HOME, P.A.
11750 BELAIR ROAD KINGSVILLE, MARYLAND 21087 21 SIGNATURE OF FUNERAL SERVICE LICENSEE postos 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. intarvsi Between Onset and Death **IMMEDIATE CAUSE (Final** disesse or condition resulting in desth) Carcinono BILLARY 15 MONTHS DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause Enter LINDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEDUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL:
t | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Assidence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 1 Natural
2 Accident 5 Pending Investigation t YES 2 NO PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Routs Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 1. GERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D30929 10/11 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CELANIO 6569 Charles BALTMAN MA N 32. REGISTRAR'S SIGNATURE

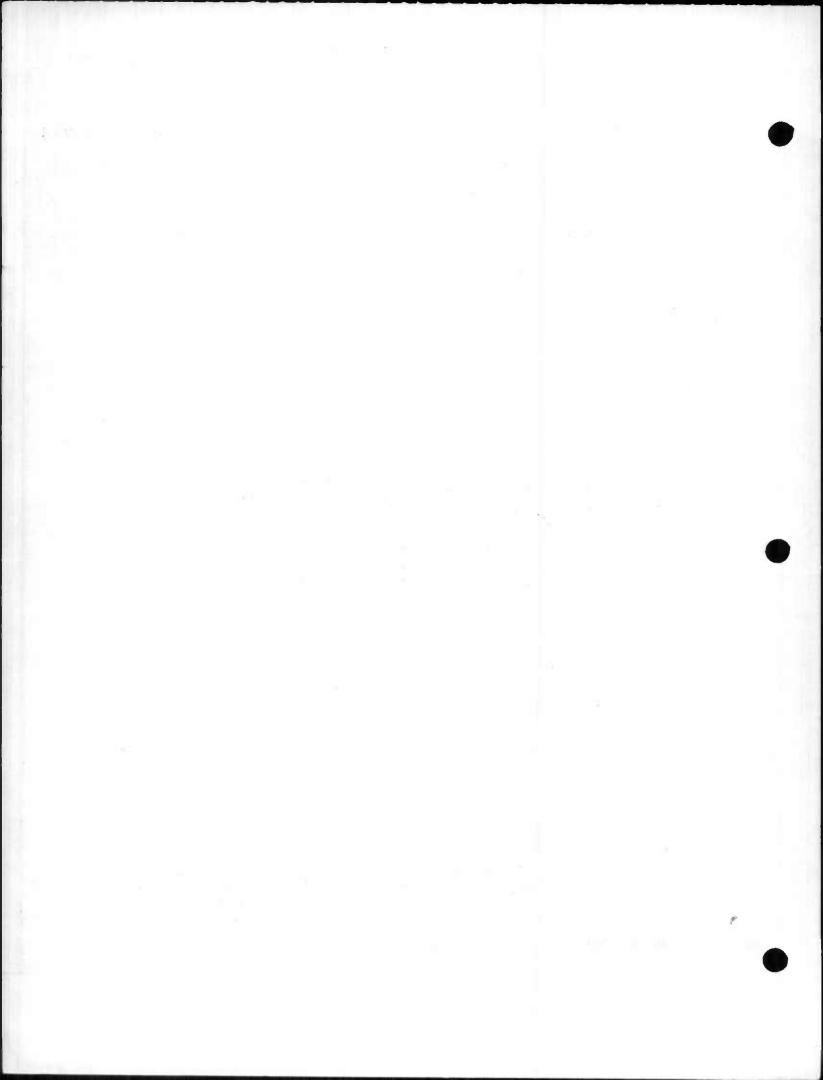
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR												
1. DECEDENT'S NAME (First, Middle, Last)	DENT'S NAME (First, Middle, Last)		COLBOURN				2. DATE OF DEATH MONTH DAY DC+, 09 199.			YEAR 95		
4. SOCIAL SECURITY NUMBER 217-66-8652	5. SEX	6. AGE (In yrs. In 98	est birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS I	HRS.	7. DATE OF (Month, D		907	S. BIRTH Countr	IPLACE (State or Foreign Ty) UNK
				0.000					.12-1			
	e. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER			96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			ATH	1.1	9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT										14/ 2.		
10a. STATE 10b. COUN	TY		10c. CIT	TY, TOWN O	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
MD. N/A			BAI	TIMO	_							1 X YES 2 NO
100. STREET AND NUMBER 607 PENNASYLV	ZANTA A	VENUE				. ZIP CODE 21217	,			US		WHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDEN		RMED	12.3		ENDENT OF I		C OBIGINS (Specify Ves			E American Indian,
1 Never Married 2 Married 3 X Widowed 4 Divorced		YES 2 X		at at	If yes, sp	ecify Cuban, (Mexicen	, Puerto Ric		W NO.	Speci	k, White, atc.
15. DECEDENT'S ED (Specify only highest grad		(ECEDENT'E	work done d	CCUPATIO	ON ist of working		16b. K	IND OF BUS	INESS/INC	DUSTRY	
Elementary/Secondary (0-12) UNK	College (1-4 or 5	+) UN	ile. Do NOT u	ise retired.)				UNI	7			
17. FATHER'S NAME (First, Middle, Last)		TON	N			I an atomics	DIO 1144			0		
							MAN C I	NE (First, Mid	ure, melcen :	ourneme)		
UNK						UNK		III.				
19a. INFORMANT'B NAME (Type/Print)		1	96. MAILIN	G ADDRESS	3 (Street a	and Number or	Rural A	oute Number,	City or Town	r, State, Zip	Code)	
MARITES RIBA	KOW		607	penr	nasy	y1van	ia	AVE	BAL	ro.	MD.	21217
20g METHOD OF DISPOSITION 1 W Burlel 2 Cremetlon 3 Re	moval from State	20b. PLACI	E AND DATE	OF DISPOS	SITION (Na	ime of		DATE	20c. LO	CATION -	City or To	own, Stata
4 Donation 5 Other (Specify)		_ MT.	ZION	CEN	MER'	ry 10	-18	B <u>-95</u>	L	ANSD	<u>NWO</u>	E, MD.
21. SIGNATURE OF FUNERAL SERVICE L	JCENSEL			22.1		ND ADDRESS		WYL]	E I	F/H	PA	
23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition	Atat Dnly one cau	at caused the cause on each line	ne.		638	8 N.	GII	LMOR	STRI	EET	21	
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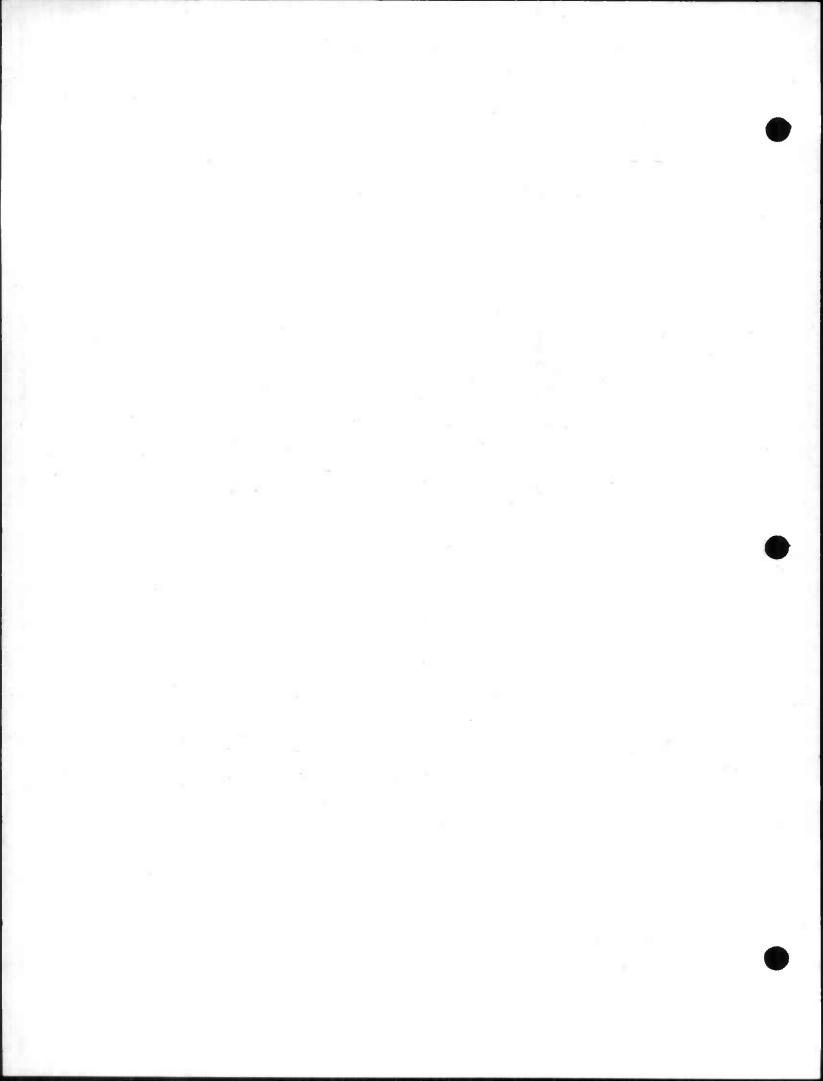


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IMPORTANT: II

spital or attending physician.	led for use as the burial-transit permit. Pages 1, 2,		
HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atter	OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1,	e filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH October 10, 1995 11:45 A JOHN DAGOSTINO 7. DATE OF BIRTH
(Month, Day, Year)
Jan 12, 1938 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) s. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 D F Pennsulvania 190-26-2876 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4010 North Point Road DIRECTOR Dundalk Baltimore 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Pennsylvania Somerset Windber 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 307 Hayes Street 15963 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yee, specify Cuben, Mexicen, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Merried 2 Merried 1 TYES 2 NO Specify BΥ 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver 12 th Self Employed 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Surneme) Frank Dagostino
198. INFORMANT'S NAME (Type/Print) Rose Petronia BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sally Dagostino 307 Hayes St., Windber, PA 15963 20e. METHOD OF DISPOSITION
1 IV Burlal 2 ☐ Cremetion 3 ☐ Removal trom State 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State DATE 1 D Burial 2 Cremetion 3 4 Donetion 5 Other (Specify) Berkey Cemetery October 13,1995 Windber, Pennsylvania 21. SIGNATURE OF POWER A SERVICE LICENSEE Data Recens Finishal Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 Enfer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. Approximata Onaet and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Arrest Condock Hypertension CERTIFICATION Sequentially list conditiona, QUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 TYES 2 NO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☑ NO ☐ UNCERTAIN ☐ PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Reeldence 27. MANNER OF DEATH 28a. OATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? Natural -5 Pending 1 YES 2 NO В Investigation 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1/Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) BE Thomas 05-006925-6 10-11-95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 00 Bloom Frold St Stelo1 Johns town Jaly Wholes hardet



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH ARY DIETZ October 40 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign April 25, 1936 213-34-4089 DAYS HOURS 1 - M 2 X F 59 YRS. Maryland Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNION MEMORIAL DIRECTOR HOSPITAL N/A BALTIMORE CIT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Edgemere 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 2813 Willow Avenue 21219 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BE COMPLETED BY 3 (Widowed 4 Divorced Specify: White 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Michael Sakowski Martha (Unknown) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5010 Erdman Ave. Baltimore, Maryland Curtis Morris å 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 V Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest V.A. Cem. 10/16/9\$ Donation 5 Other (Specify) Owings Mills. MD 21. SIGNATURE OF PLINEDAL DESVICE LIGHT 22. NAME AND ADDRESS QE FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 medical PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) **Onset and Death** ě disease or condition_ 45min event, resulting in death) DUE TO (OR AS A CONSE traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST LOS PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF OFATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 - YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural COMPLETED BY Investigation 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) end manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year MIK 2438 October 2 NESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

Memor

Union

Mikhail 31. DATE FILED (Month, Day, Year) OCT 1 7 1995 32, REGISTRAR'S SIGNATURE

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FOR STATE REGISTRAR

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	4. SOCIAL SECURITY NUMBER	5. SEX	□ F	rs. last birthday) YRS.	IF UNDER 1 Y	TEAR IF UNDER HOURS 1 13	M 24 HRS.	7. DATE OF (Month, D	3/95	Mary Mary	ACE (State or Foreign
TOR	9a. FACILITY NAME (If not Institute of DECE	ty of mo	aryland	Medica		em E	pattern			N/A	TH .
DIRECTOR		N/A		10c. CIT	Y, TOWN OR I	timore					A. INSIDE CITY LIMITS? XXYES 2 NO
IERAL	100. STREET AND NUMBER 5817/2 North	Hazelwood	d Avenue			10f. ZIP CO	1206		US/		AT COUNTRY?
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BE COM	17. FATHER'S NAME (First, Mich David Char		r						dle, Maiden Surname) DiMolla		
10	Mr. & Mrs. [r	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7					chy or Town, Sheha, Zip ue Baltimo		d 21206
	20. METHOD OF DISPOSITION 1 X Burlan 2 Cremation	3 - Ramoval from S		LACE AND DATE				10/1	7 Parktor		
	DONNES &	SERVICE LICENSEE	Vena	kis		ME AND AODR	1	Mitch	ell-Wieden		
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	E OF MARYLAND /	DEPARTMEN ERTIFICAT				YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	DEATH DAY	YEAR	3. TIME OF DEATH
	VIRGINIA ELIZAE	6. AGE (In yrs. les	DEIT	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	ER 14, 1		12:27P M PLACE (State or Foreign
	215-48-9333	2 X F 42	YRS. MONTHE	DAYS	HOURS MIN.	March March	9, 1953	Mar	yland
œ	9e. FACILITY NAME (If not institution, give street end in THE TOUNG HODET)		9b. Cl		MODE CT			INTY OF D	ORE CITY
THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT						11			
DIRECTO	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LO				r frien	DSHIP			10d. INSIDE CITY LIMITS? 1 YES 27 NO
AL	10e. STREET AND NUMBER						10g. Cl	FIZEN OF V	VHAT COUNTRY?
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BY FU				If yee, spec	NDENT OF HISPA lify Cuben, Mexico NO Special	en, Puerto Ricar	pecify Yes or No— n, etc.)	14. RACE Black Speci	- American Indian, t, White, stc.
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E	Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)	. Do NOT use retired	1.)			Clerica	1	
COMPL	1.2 17. FATHER'S NAME (First, Middle, Last)		Bookeep	er	16 MOTHER'S NA	ME /First Middl	e. Meiden Surnemei	T	
E C	JOHN STANLEY HARE	RISON					ENCE APP	LEBEI	
0	19e. INFORMANT'S NAME (Type/Print)		b. MAILINO ADDRE	SS (Street en	d Number or Rural	Route Number, C	City or Yown, State, 2	(ip Code)	
2	MR. MICHAEL J. DEITZ	Z	12795 B	UTTER	CEP COU	RT WEST	r FRIEND	SHIP,	MD 21794
	20e. METHOD OF DISPOSITION 1 □XBurlet 2 □ Cremetion 3 □ Removal from	20b. PLACE cametary, cri	ANDDATEOFDISP ematory or other place View Me	OSITION (Nan	ne of	DATE	20c. LOCATION -		
	4 Donetion 5 Other (Specify)	Lake			ADDRESS OF F	0/18/9! NCILITY	Sykes	VIIIE	:, FID
	· Brian A.	Haislet	- 2				E (P.O. 784 (410		
	23. PART I. Enter the diseases, or complic shock, or heart failure. List on	ations that saused the de y one cause on each line	eath. Do not ent	ter the mod	e of dying, aud	ch as cardiac	or reapiratory a	rrest,	Approximate interval Batween
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	ASCENDING AL	ortic o	disse	ction (Type	A)		2 hours
z		9				,			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	QUENCE OF):						
5	cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):						
E	resulting in death) LAST								
	PART il. Other algnificant conditions contr	ibuting to deeth but not	resulting in the	underiving	cause given in	Part I. 24	II. WAS AN AUTOPS	7 246	. WERE AUTOPSY FINDINGS
CAL	Hypertension			and only mag	g.vo.r.		PERFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	177						X 123 2 110		OF DEATH?
N.	DID TOBACCO USE CONTRIBUTI	TO CAUSE OF DEA	ATH YES	NO 🗆	UNCERTAI	N 🗆			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLA	CE OF DEATH (Che						
YSI	1 YES 2 NO 1 I I In	patient 2 - ER/Outpatient	3 DOA 4 D	Nursing Home	5 - Residence				
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	26c. INJU WOF		26d. DESCRI	BE HOW INJURY O	CCURED	
ВУ	Accident Investigation 3 Suicide 6 Could not be	Se. PLACE OF INJURY — At h	ome, ferm, street, f				ON (Street and Numb	er or Rural	Route Number,
COMPLETED	4 Homicide determined	bulluling, sec. (Specily)				City or R	own, State)		
PE	29e. CERTIFIER (Check only) CERTIFYINO PHYSICIAN: To	the best of my knowledge, d	eath occurred at th	ne time, date	end piece, end du	e to the cause(e) end manner ee s	tated.	
ŏ Ö	one) 2 MEDICAL EXAMINER: On th	e basis of examination end/or	Investigation, in m	ny opinion, de	ath occured at th	e time, date end	d place, end due to	the cause(e) end menner ee stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER	foul I De	NO MI	0	D436	IMBER 80	29d. D/	Octo	Month, Day, Year)
2	30. NAME AND ADDITES OF BERSON WHO SOME	TED CAUSE OF DEATH (IT	IM 27) (Kipe, Print)	. 11	-01/	(00)	10/17	15-1	1 0 11 mm
	31. DATE FILED (Month, Day, Year)	HEGISTRAN SIGNATURE	HOPKIN	S Ho	Spilal	600	IV. No	178	T., 56 (10, M)
	OCT 1 71995 dali An	1	762						dis



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)	·	0			2. DATE OF DEATH		3. TIME OF DEATH
	Diane Dennis					MONTH DA	ar	CAM "
			r yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1 13	ITHPLACE (State or Foreign
			7 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) June 15,	Cor	intry)
,	9a. FACILITY NAME (If not institution, give street	et end number)		9b. CITY, TOWN	R LOCATION OF DE		9c. COUNTY OF	
DIRECTOR	Bayview Hosp	ital			Baltimo	re	N	/A
R	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
		timore		Ess				1 TYES 2 NO
FUNERAL	100. STREET AND NUMBER	n 1		10	ZIP CODE	21	10g. CITIZEN O	F WHAT COUNTRY?
y	155 Bennett 11. MARITAL STATUS		II S ARMED	12 WAS DEC		L I HC ORIGIN? (Specify Yee		ACE — American Indian.
	1 Never Married 2 X Married	ECOCCES 1 VES 2 VIO				n, Puerto Rican, etc.)	8	ack, White, atc.
ВУ	3 Widowed 4 Divorced				- <u>A</u>			White
TED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	(Give kind of	USUAL OCCUPATION		16b. KIND OF BUS	SINESS/INOUSTR	
COMPLET		College (1-4 or 5+)	House				OWN	home
M	8th 17. FATHER'S NAME (First, Middle, Last)		поиѕе	wire	16. MOTNER'S NA	ME (First, Middle, Melden		Home
ŏ	William Ka	nne1				ouise Wi		
BE	19e. INFORMANT'S NAME (Type/Print)	ppci	19b. MAILING	ADDRESS (Street		Route Number, City or Town		
유	Wayne Dennis		155	Benne	tt Road	Balitmo	re Md.	21221
	20a. METNOD OF DISPOSITION ☐ Burlel 2 ★ Cremetlon 3 ☐ Remov	20b.		OF DISPOSITION (Nather place)		0/19/95	CATION — City of	
	4 Donation 5 Other (Specify)		etro Ci		Y TITC . I		Darcin	ore ma.
	* R TOLL	1 (0000	.01.1	Conn	elly Fu	neral Hore. Balti		
	23. PART I. Enter the diseases, or co							Approximate
	shock, or heart fallup Id iMMEDIATE CAUSE (Final disease or condition	5	1					Onset and Death
	resulting in death) a.	DUE TO (OR AS A		NF):				eacy >
z		Adult D	espua	toru -	Distress	Syndn	amo	8days
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F): J		-4		
2	cause. Enter UNDERLYING CAUSE (Diseess or Injury	DUE TO (OR AS A	CONSEQUENCE O	NF):				
F	that initiated events resulting in death) LAST							
	0.					I		
SAL	PART II. Other significent conditions	contributing to death be	ut not resulting	in the underlyin	g cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
EDIC						1 🗀 YES 2	X NO	OF DEATN?
Σ	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DFATH Y	ES [] NO [UNCERTAIL	N PA		1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL			TN (Check only one)	- OTTOEKIANI			TO.
SIC	EXAMINER? 1 Tyes 2 No	HOSPITAL: 1 X Inpution: 2 ER/Outp	atient 3 DOA	OTHER:	ne 5 🗆 Residence	6 Other (Specify)		
PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Yeer)	26b. TII	JURY W	JURY AT DRK? YES 2 NO	28d. DESCRIBE NOW I	NJURY OCCURE	
В	2 Accident Investigation 3 Suicide Could not be	28e. PLACE OF INJURY	— At home, ferm,			281, LOCATION (Street	end Number or Ru	ral Route Number,
TED	3 Suicide 8 Could not be 4 Nomicide determined	building, atc. (Spec	ify)			City or Town, State)		
PLE	29e. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edge, death occur	red at the time, dat	and piece, and due	to the ceuse(a) end me	nner ea atated.	
COMPLET	one)	On the beels of examination	and/or investigati	on, in my opinion,	death occured at the	time, date end place, er	nd due to the ceu	se(e) end menner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	77.6	29d. DATE SIG	NED (Month, Day, Year)
TO E	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLSE OF DE	ATN GTEN 27 /3-	- Print)	1 H6	340	101	16175
	D. McClay MD	Johns Hat	okins 1	Bauvier	W Hospi	tal 4940	Eastern	AUR BALTMO
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	TURE		1			
	OCT 1 71995 Jul	Was and the second	4.46	-:-				DHMH-16 Rev 1/89

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PITAL OR ATTENDING PHYS	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMEN CERTIFICAT	IT OF HEALTH AND	MENTAL HYGIEN	_	
	1. DECEOENT'S NAME (First, Middle, Last)	Farmer			2. DATE OF DEATH DO		3. TIME OF DEATH 12:50 PM
	4. SOCIAL SECURITY NUMBER 217-03-8742	1 □ M 2 🗆 🗶 🖠 88	YRS. MONTHS		7. DATE OF BIRTH	OOC Cou	THPLACE (State or Foreign ntry) GINIA
TOR	96. FACILITY NAME (II not institution, give str MELCHOR NURS RESIDENCE OF DECEDENT	-	9b. Cl	BALTIMORE	CITY	9c. COUNTY OF	
DIRECTOR	100. STATE 100. COUNTY MARYLAND	n/a	10c. CITY, TOWN	BALTIMORE			10d. INSIDE CITY LIMITS? XXX YES 2 NO
FUNERAL	501 E. PRESTON	STREET		101. ZIP CODE 2120	2	UNITED	STATES
В	11. MARITAL STATUS 1 Never Married 2 Married 3 X X Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMEO ::	I. WAS DECENOENT OF HISPA If yes, specify Cuben, Maxic 1 YES 2/YNO Spec	en, Puarto Rican, atc.)	914	CE — American Indien, lock, White, atc.
COMPLETED	1s. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 6 th	ATION 16a completed) College (1-4 or 5+)	DECEDENT'S USUAL (Give kind of work don life. Do NOT use retired DOMESTI	e during most of working)		SINESS/INDUSTRY	ne
BE CON	17. FATHER'S NAME (First, Middle, Last) UNKNOWN				AME (First, Middle, Meiden Known	Surname)	
5		TTEN	501 E.	SS (Street and Number or Rural PRESTON ST			21202apt.8
	20a METHOD OF DISPOSITION X Buriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNEBAL SERVICE LICE	val from State cemetery	ceand date of dispersion of other place.	CEMETERY	10-18-95	CATION — CITY OF LANSDOWN	
	Amer	Tex.	nes	WM.C . MARC	HFH1101		RTH AVENUE
CERTIFICATION	25. PART I. Enter the diseases, or concluded to the condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	let only one ceuse on each	NSEQUENCE OF):	er the mode of dying, su		Iratory arrest,	Approximate interval Between Onset and Death 2
PHYSICIAN: MEDICAL CE	PART II. Other significent conditions DID TOBACCO USE C				PERFOR	RMED?	Ib. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatien	отн	28. PLACE OF DEATH (C	heck only one)		
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUREO	
	3 Suicide 8 Could not be datermined	28e. PLACE OF INJURY — A building, etc. (Specify)	it home, ferm, street, te	ctory, office	28t. LOCATION (Street a City or Town, State)	and Number or Rura	l Route Number,
COMPLETED	amal .	IAN: To the best of my knowledge I: On the basis of exemination and					(s) and manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	- Attenday	oh, sician		4	10/1	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO MURE D. JURGE 31. DATE FILED (Month, Day, Year)	low, one 30	1 St. Pa.	ul Mace L	Ra 1 towner	mo	2/200
	OCT 1 7 1995 Jul	32. REGISTRAR'S SIGNATUR	L.				

1995

U.S.A.

Specify:

3. TIME OF DEATH

10:45

B. BIRTHPLACE (State or Foreign

Virginia

10d. INSIDE CITY

14. RACE --- American Indian, Black, White, etc.

White

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town. State)

Interval Between Onset and Death

1 YES 2 XNO

AM

DIVISION OF VITAL RECORDS, P.O. BOX 68760

has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		
should be detached		ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
page 5		rt be no
I director		ner mus
le funera	al.	examir
d in by th	or remova	medical
rtefy filled	al, cremation, or	it, the i
d comple	urial, cre	lic even
sician an	prior to b	trauma
rid gnibr	Hygiene	r other
the atter	Mental	njury, a
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as be	Dept.	23 \$
cate h	State	Itеm
Sertifi	the !	, Or
r this (th with the State Dept. of Health ar	arked

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

PHYSICIAN: MEDICAL CERTIFICATION

marked,

BY

COMPLETED

BE

2

3 Sulcide

4 Homicide

8 Could not be

DIRECTOR: After the hours after death vitem 28 is mari

FUNERAL | IMPORTANT: II

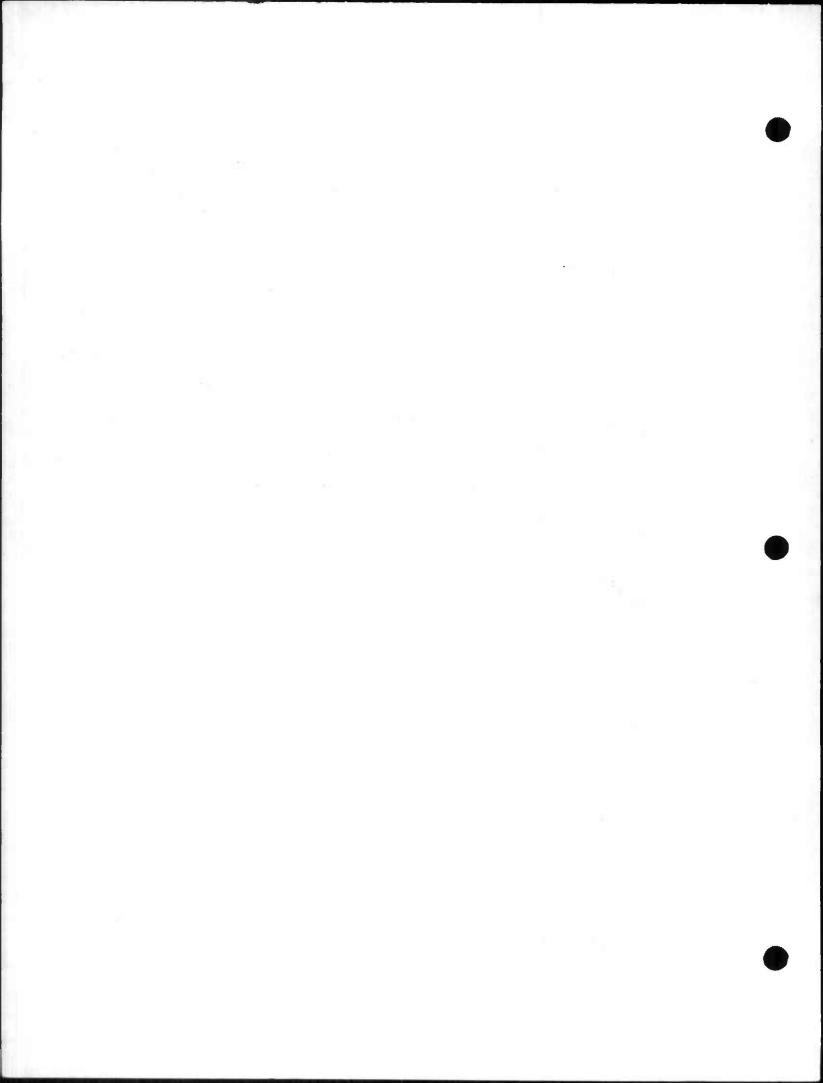
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 13 Noel Francis Sr. October 0 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 🔀 M 2 🗌 F 89 Sept. 12,1906 228 05 8939 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel 620 Sunset Strip Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT Maryland Anne Arundel Baltimore 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21225 620 Sunset Strip 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 X Married 1 YES 2- NO Specify: 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Bethlehem Steel Corp. 4th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marshall Francis Emma E. Waller 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 253 Carroll Road Harry M. Francis 20s. METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata Meadowridge Memorial Park10/17 Baltimore, Maryland 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Richard E. George J. Gonce Funeral Home P.A. ano 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART i. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition DUE TO (OR AS A CONSEQUENCE OF): Brain metastatic resulting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL 1 - YES 2 1 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident

29a. CERTIFIER
Thank and 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besie of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF SEWTIFIER 29d. DATE SIGNED (Month, Day, Year) P22782 LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

28a. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)



B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-728 10/27/95 t.t

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	CI		CATE OF		REG. I	NO.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	ROBERT	Ţ	FLEE	\mathbf{T}		OCT.	12.1995	0733 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIF	ITHPLACE (State or Foreign
	212-40-6784	1 M 2 D F 49	YRS.	MONTHS DAYS	HOURS MIN.	Jan 1.	1946 18	DRIVANITO
	9e. FACILITY NAME (If not institution, give stre	set end number)			R LOCATION OF DE		9c. COUNTY OF	DEATH
OR	2201 KLOMAN AVE	ENUE		BALTI	MORE C	ITY		1/9
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40. 007	V 70404 00 1004T	āu.			I are made and
Ë	MA	NIA	100. 011	BA 1	100 M			10d. INSIDE CITY
	10e. STREET AND NUMBER	-///		1112-171	ZIP CODE		100 CITIZEN O	1 √YES 2 □ NO F WHAT COUNTRY?
RA	2427 1/66	19mm7 57.		101.	2172	50	11.	S. A.
FUNERAL	11. MARUTAL STATUS	1. WAS DECEDENT EVER IN U.S. AR	UMED .	13. WAS DECI	ENDENT OF HISPAN	VIC ORIGIN? (Specify	Yee or No.— 14. R/	ACE — American Indian.
	1 Never Merried 2 Married	FORCES? 1 YES 2 1 F YES, GIVE WAR OR DATES	NO		city Cubarr, Maxice	n, Puerto Ricen, etc.)		ack, White, atc.
BY	3 Widowed 4 Divorced			1	- open		13	FACK
	18. DECEDENT'S EDUCA (Specify only highest grade of	completed) (G	ilve kind of v	USUAL OCCUPATIO		18b. KIND OF	BUSINESS/INDUSTRY	
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)	Do NOT us	ie retired.)	,	1 3	21 10 75	
COMPLETED	71//	/	YAV	VYMAN	/		1011112	
8	17. FATHER'S NAME (First, Middle, Lage)	7		/	18 MOTHER'S NA	ME (First, Middle, Mgi	Sumame)	
BE	100 IMPORMANT'S MAME (TOWNSHIE)	7	h MAII INC	ADDRESS (Street or	THYV	Route Number, City or	Town, State, Zip Code)	
2	MARY RANDA	11_	24	2711/	1-1-00	15/14	2n17 W	to 11130
	20s. METHOD OF DOMOSCHON	20h PLACE	ANDDATE	DEDISPOSITION (Na	ment /	DATE 1.206	LOCATION - City or	Town State
	1 Denetion 1 Other (Specify)	val from Stats	15 7x	77	117	111/05	30/ 1/2m	10/10
	21. SIGNATURE OF THERAL SEMPLE LICE	INSEE /	10-1	22. 904(1) 43	and the state	NOFALE	DI NIN	TIME VA
	+ May 177	16		DAIL STAN	Stan	11 177 19	12 5 42	NT CALLAN
	23. PART Lintel the diseases, or co	omplications that caused the de	eath Do r	not enter the mo	TIBU	MLHM/	47) 0	Approximate
	shock or heart failure. L	ist only one cause on each line			so or cynig, suc		aphraioty arrest,	Interval Batween Onset and Death
	IMMEDIATE CAUSE (Final disease or condition	NARCOTIC AND COO	ATNE	INTOXICATI	ON COMPLIC	ATEN DV DD	NUNTHE	Onset and Death
	resulting in death) a.	DUE TO (OR AS A CONSE			on cometic	AILD DI DK	MUTUR	
z								
9	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE O	F):				
S	CAUSE (Disease or Injury c.							
H	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE O	F):				
CERTIFICATION	d.	·						
	PART II. Other algnificant conditions	contributing to death but not	resulting	in the underlying	cause givan in			24b. WERE AUTOPSY FINDINGS
2						1	FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
								OF DEATH?
÷	DID TOBACCO USE CONTR	BUTE TO CAUSE OF DEA	ATH YE	S NO C	UNCERTAIL	N 🗆		
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEA	TH (Check only one)				
S		HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA	OTHER: 4 Nursing Hom	5 🗆 Rasidence	Manual Control (Specify)		
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	PRON	WINCED 28c. INJ		28d. DESCRIBE HO	W INJURY OCCURED	
BY 1	1 Netural 5 Pending 2 Accident Investigation	FOUND 10/12/95	7:33	A ^M 1 🗆 Y		UNKNOWN		
	3 Suicide 8 XX Could not be	28e. PLACE OF INJURY — At he building, etc. (Specify)				26f. LOCATION (Str. City or Town, St	eet and Number or Rui	al Route Number,
COMPLETED	4 Homicide determined	FOU	ND IN	WATER		2201 KLOMA	N AVE. BALT	O., MD.
<u> </u>	(Orlock Orly)	CIAN: To the best of my knowledge, de	esth occurr	ed at the time, data	end place, and due	to the cause(s) end	menner as atated.	
O.	one) 2 X MEDICAL EXAMINER	R: On the basis of exemination and/or	investigation	on, In my opinion, d	esth occured at the	time, date and piece	, end due to the ceu	se(s) end menner es statad.
ш	29b. AGNATURE AND TITLE OF CENTIFIER	1/ 10			29c. LICENSE NUI	MBER	11.71	IED (Month, Day, Year)
TO B	Mulgone me	Jall			O.C.M.	E	▶OCT.	13,1995
Ĕ	30. NAME AND ADDRESS OF PERSON WHO	111	M 27) (Type	Print)	et. Ral	timore	Marvla	nd 21201
		ACTU PID	1 61	III DELE	ce, bul	- Camoro,		
	OCT 1 71995 Juli	12. REGISTELAR'S SIGNATURE						
	100 I 1 1333 AM	Y AN AUTOMORPHAN AND AND AND AND AND AND AND AND AND A						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing 4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

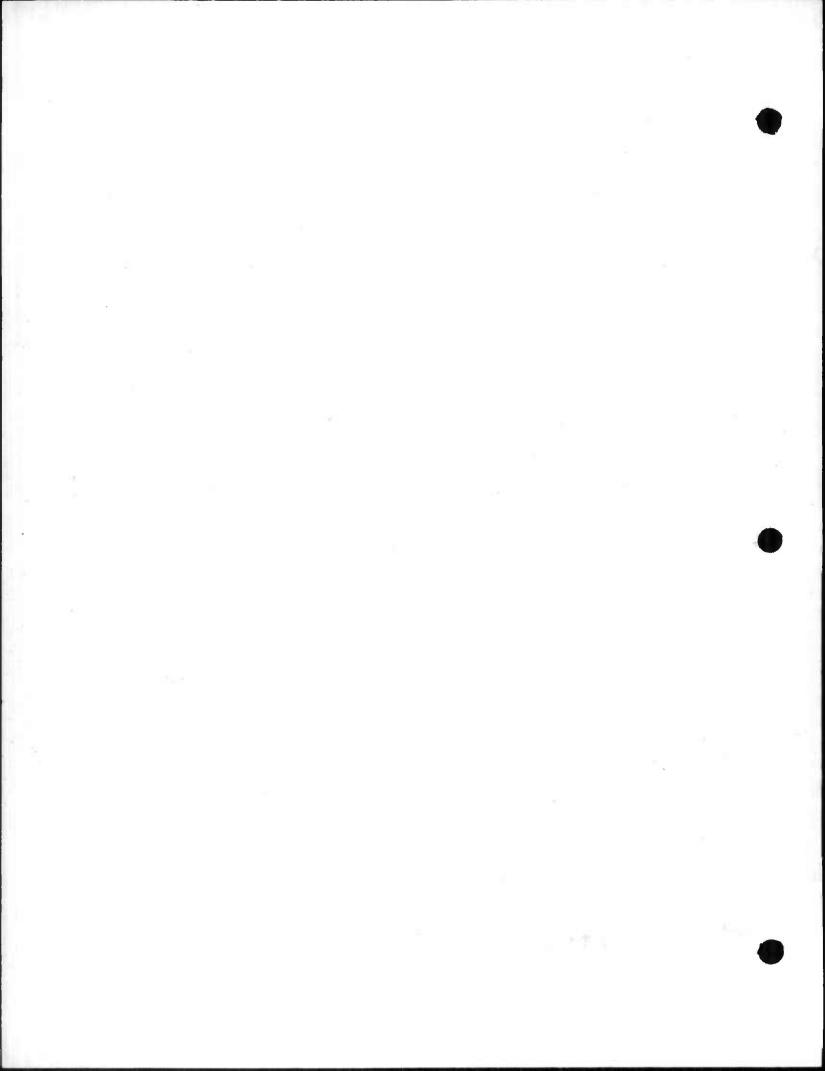
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
-	be fled within 72 hours after death with the State Dept. of Health and Mental Hygienii prior in burial, cremination, or remove
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death. Page 8 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the local may be retained by the hosp

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DE BORAH
31. OATE FILEO (MORTH, Day, Year)
UCT 1 7 33

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Item1 10-17-95 FilmG728 W.H.Per F/H										
1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.											
1. DECEDENT'S NAME (First, Middle, Lest) Nakiera Shantell Forrest 2. DATE OF DEATH MONTH DAY VEAR 3. TIME OF DEATH							TIME OF DEATH				
Nakie	fa	100	25	Juance	II FOL	rest	10 1		2 1	995 =	3:12 A M
4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YEA			TE OF BIRTH onth, Day, Year)		8. BIRTHPL	ACE (State or Foreign
213-45-25	50	1 M 2 F		YRS.	MONTHS DAY	B HOURS MIN.	JUI		1995	Country)	MD
90. FACILITY NAME (If not in	stitution, give st	reet end number)			96. CITY, TOW	N OR LOCATION OF C	EATH			TY OF DEAT	
SINAI HOS					BALT	IMORE				N/	A
RESIDENCE OF DEC	10b, COUNTY			40.00	Y, TOWN OR LO						
MD.		N/A				RE CITY					d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER				101	1011110						YES 2 NO
2709 GWY	MMC E	ATTC DA	DIZLIAV			10f. ZIP CODE	1.0				T COUNTRY?
11. MARITAL STATUS	MIND I	12. WAS DECEDEN		ABMED	1 40 1110 0	212				.S.A	•
1 Never Married 2 3 Widowed 4 Divo		FORCES? 1	YES 2	XNO	If yes,	SPECENDENT OF HISPA specify Cuben, Mexic (ES 2 NO Speci	an, Puerl	GIN? (Specify Yes to Rican, etc.)	or No—	14. RACE — Black, W Specify: BLA	Americen Indian, filte, etc.
15. DEC	EDENT'S EDUC	CATION	18e. I	DECEDENT'S	USUAL OCCUPA	TION	.1	6b. KIND OF BUS	INESS/IND		
Elementary/Secondary (0		College (1-4 or 5		life. Do NOT us	work done during se retired.)	most or working					
0		N/A		N/A				N/A			
17. FATHER'S NAME (First, M.	liddle, Last)					18. MOTHER'S N.	AME (Firs	t, Middle, Maiden S	Sumame)		
ATWAUN		FORRE	ST			NIKKIA	A		POMP	EY	
190. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRESS (Street	et end Number or Rural	Route Nu	imber, City or Town	, Statu, Zip	Code)	
NIKKIA POL	MPEY			2709	GWYNS	S FALLS	PAI	RKWAY	BALT	O, M	D 21216
20a. METHOD OF DISPOSITION 10 Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State						State MD					
21. SIGNATURE OF EUNERA	L SERVICE LICE	ENGER		1		AND ADORESS OF FA	ACILITY				
1 hans	ULA	1/100	BETTS FUNERAL HOME								
23 PART I. Enter the diseased or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory erreat, Approximate						9 N. CAL	ROT.	TYP ST	RA	T.TO I	MD21212
23. PART I. Enter the di	seeset, or c	omplications tha	t caused the	deeth. Do r							
snock, or ne	eart gamure. L	omplications tha list only one ceu	it caused the dise on each life	deeth. Do r							Approximata Interval Between
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IMMEDIATE CAUSE (Fin	eart gallure, t nai	Conce	OR AS A CONS	no. LHC	enter the react	node of dying, suc	ch ea ca			eat,	Approximate Interval Between Onset and Death
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death,
	ATTENDING
-	OR
-	HOSPITAL

		1 - STATE REGISTRAR	2	IAIE UF I	MARYL	AND / DEI CERT						MENTA	AL HYGIEN REG. NO	_		
		1. DECEDENT'S NAME (First, Middle,	Last)	FOR	e VII	116						MON			YEAR	TIME OF DEATN
		4. SOCIAL SECURITY NUMBER	5. S			(In yrs. lest birth		F UNDER		IF UNDER	24 HRS.	7 DATE	OF BIOTH	T e	995 BIRTNPL	ACE (State or Foreign
95		222-03-4959 De. FACILITY NAME (If not institution,		M 2 □XE	77	YF	S.	ONTHS	DAYS	HOURS	MIN.		th. Day (191), 1	IV.	aryle	
. 2, 3 should	стов	Charlestown R	etire		?ommu	nity				or LOCATION		EATH		Balt		
Pages 1,	ш	10e. STATE 10b. C	OUNTY				10c. CITY, TOWN OR LOCATION Catonsville									d. INSIDE CITY
permit. P	L DIR	Maryland Ba	ltimo	re			Cat	ons		ZIP CODI	-					YES 2 NO
38	FUNERAL	715 Maiden Chi	oice	Lane					101	2122				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
215-0020 attending physician. se as the burlal-transit	Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		WAS DECEDENT FORCES? 1 F YES, GIVE N	YES			1 1	f yes, spe	ENDENT Cooking Cube	n, Mexica	en, Puerto Ricen, etc.) Blac				American Indien, Thite, etc. White
	ETED	15. DECEDENT'S (Specify only highest				18e. DECEDER	8e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY									
AND ZI he hospital or setached for u once.	집	Elementary/Secondary (0-12)	1	lege (1-4 or 5	+)		tousewife									
at on at on	BE CO	17. FATNER'S NAME (First, Middle, Lea Thomas Randol	f Foa										Middle, Maiden rtrude		on	
make retained by a 5 should be notified at	TO E	190. INFORMANT'S NAME (Type/Print) Frank Forsythe		sband)		19b. MAII 715	ING AD	ide	(Street a	nd Number	or Rural F Lan	Poute Nun	R517-BO	n, State, Zip C Utimo	re, 1	ND. 21228
hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be 1		20a. METHOD OF DISPOSITION 1		rom State	20b	PLACE AND Dinetery, cramatory	TEOF C	DISPOS r place)	ITION /Na	me of		DA	TE 20c. LO	CATION — CH	y or Town	Stata
death. Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE		E Rona	ld Wg	ide, Di	r.	22. I	NAME AN	D ADDRES	S OF FAC	Roa	nd-655	(v) Ra	Ptim	ore Street
S after deat rs after deat removal.		acest 13	K	yer.	Se	est		Rn	1.B0:	26-Bo	ultin	nore	, Mary	land	2120	1-1559
DALII 24 hours after death. P filled in by the funeral on, or removal. he medical examin		23. PART I. Enter the diseases shock, or heart fall IMMEDIATE CAUSE (Final	iure. List c	only one cau	use on e	d the death. I ach line.	o not	enter	tha mo	de of dyl	ng, such	n as car	dlec or respi	ratory arres	it,	Approximate Interval Batween Onset and Death
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E See 5	IL CE	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS														
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law requires that as been signed bept. of Health a 23 shows any		DID TOBACCO USE CO	NTRIBLI	TE TO CA	LISE O	F DEATH	YES		10 [LINC	ERTAIN		-		1 (YES 2 NO
The la rite has ate De em 2	SICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER?	AL.	SPITAL:		26. PLACE OF I	EATN (nly one)	0140	LKIAII					
e the CA	PHYS	1 TYES 2 THO 27. MANNER OF DEATH				atient 3 DO		Nurs			aldence		SCRIBE NOW II	N HIBY OCCID	RED	
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TTEND TOR: A after d	ED	3 Suicide 6 Could no 4 Homicide determin	7 00	28e. PLACE O building,	etc. (Spec	— At home, fer	m, stree	et, tacto	ery, office	ffice 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stele)					Number,	
B B B C E	OMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING 1														d manner es stated.
TO THE HOSPI TO THE FUNER De filed within	BE CO	296. SIGNATURE AND TITLE OF CER		0						29c. LICE						inth, Day, Year)
5 5 3 W	5	30. NAME AND ADDRESS OF PERSO	M WHO CON	IPLETED CAU	SE OF DE	ATH (ITEM 27)	ype, Prii	D47020					Detaler 10,1985			
		PATRICIA J. 31. DATE FILED (MONTH, Day, Year)	JOKN		11.	MARI	EN	j	C	to ice	=	CAN	1É	CATON	SVICE	E,MO 21238
		OCT 17	1905	fully	Dan	HURE RAN	all									

. . DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL C THE FUNERAL D filed within 72 ho

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death. Page 6 may be retained by the hospital or attending physician.	I funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attent	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH RICHARD M. FORBES 10-06-1995 3:10 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 10-03-1915 HOURS 1 X M 2 - F 217-12-7022 80 YRS MARYLAND 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ELKRIDGE ESTATES N/A BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE N/A 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6011 HUNT RIDGE RD. 21210 U.S.A. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced WWII WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EQUICATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) 4YRS. REAL ESTATE REAL ESTATE AGENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ħ THEODORE W. FORBES ELIZABETH H. CHEW BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 KEATING BOWIE 4190 EVERGREEN RD. OXFORD, MD. 21654. å 20e. METHOD OF DISPOSITION

1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must TRINITY EPISCOPAL Donation 5 Other (Specify) 10/95 BALTO., MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
HENRY W. JENKINS & SONS CO. William K. 4905 YORK RD. BALTO., MD. 21212. medical 23. PART I. Enter the diseasea, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heert failure. List only one ceuse on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disesse or condition ougestres 5 nears resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ò PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? ашу 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO ВУ vestigation 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 ETED. 6 Could not be 4 Homicide 28 datermined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, end due to the cause(e) end manner se stated. COMPL (Check only one) = 2 _ MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITY
TO THE FUNERA
DE filed within 7 29b. SIGNATURE AND TITLE OF CERTIFIES 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Julaon m 12427 15

31. DATE FILED (Month, Day, Year)

HUNTER WILSON

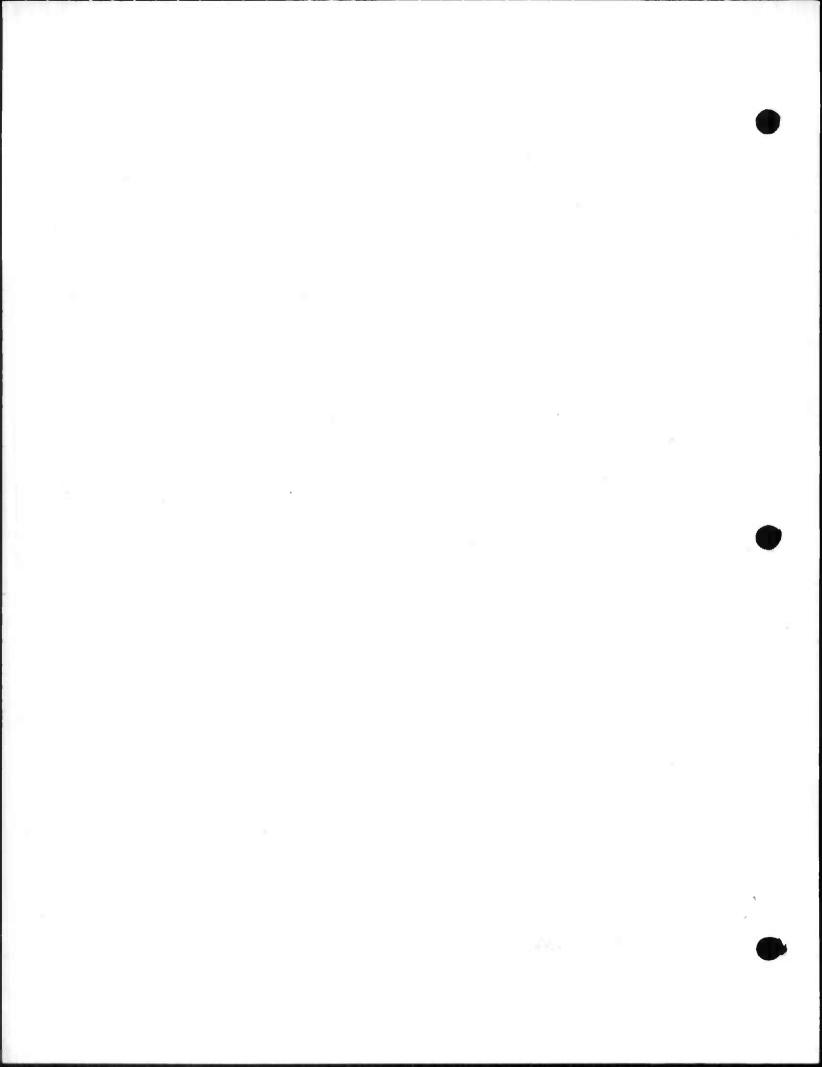
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE alin Davolear Rawfall

JR. M.D. G.B.M.C. EAST PAVILLION RM.

TOWSON, MD.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health and Mental Hygher prior burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Inliery or other traumatic event, the medical examinar must he marked at page.
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	1 - FOR STATE REGISTRAR		STATE OF N	MARYL	AND /	DEPAR	RTMENT	OF H	IEALTH DEAT	AND !	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Mide	die, Lasi)										E OF DEATH			3. TIME OF DEATH
1 3	BEATRICE	T. F	FENTON								1 ($5 - 1^{2}$	1 -19	95	11:45a w
1	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs. last	birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	214-74-7533		1 🗆 M 2 🔀 F	94		YRS.	MONTHS	DAYS	HOURS	MIN.	01.	-03-19	901	MA]	RYLAND
~	9a. FACILITY NAME (If not instituti						9b. CITY,	TOWN C	OR LOCATION	ON OF DE	ATH		9c. COU	NTY OF D	EATH
DIRECTOR	ROLAND PARK PLACE BALTIMORE N/A														
E C	10a. STATE 10b.		10c. CIT	Y. TOWN O	R LOCAT	ION					1	10d. INSIDE CITY			
H	MARYLAND N/A						BALTIMORE							LIMITS?	
	10e. STREET AND NUMBER	-11/ 11				D21.	01 111		, ZIP CODI	E			10e. CITI	VHAT COUNTRY?	
FUNERAL	830 WEST 4	10тн	STREET	٦				2	121	1			100	S.A.	F-C I SERVEN
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — Americal III. Never Married 2 Married FORCES? 1 YES 2 NO If yes, apecify Cuben, Mexican, Puerto Rican, atc.) 14. RACE — American III. Never Married 2 Married FORCES? 1 YES 2 NO III. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American III. Never Married 2 Married FORCES? 1 YES 2 NO III. NO NEVER MARRIED III. NO N										- American Indian					
BY F	1 Never Married 2 Marri 3 Wildowed 4 Divorced	led	FORCES? 1	MR OR DA	2 N	0			2 ND			Rican, atc.)		Speci	k, White, atc.
WHITE															
COMPLETED	15. DECEDEN (Specify only high	NT'S EDUCAT nesi grade co	TION mpleted)	1	16a. DEC	CEDENT'S	USUAL OC work done d se retired.)	CUPATIO	ON st of working	ng	16	b. KIND OF BUS	SINESS/IND	USTRY	
۳	Elementary/Secondary (0-12) 1 2		College (1-4 or 5 -	-)										_	
₹ I					но	USE	WIFE					HOMEN		R	
	17. FATHER'S NAME (First, Middle,		mp z TT						-			Middle, Maiden			
BE	CHARLES BAY		TRAIL				-	-				EBRENN			
임	MATTHEW C.		ON TIT		196.							nber, City or Tow		,	
	20a. METHOD OF DISPOSITION	L EW I	ON III							VE 1		NIUM,			
1 Burial 2 Cremation 3 Removal from State															
	4 Donation 5 Other (Specify) DRUID RIDGE CEMETERY 10/95 PIKESVILLE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											JE, MD.			
	N 100	1	1 -				H	ENR	Y W	. JE	ENKI	INS &			
	Williamk. VaizIII 4905 YORK RD. BALTO, MD. 21212.														
23. PART I. Entar the disesses, or complications that caused the deeth. Do not anter tha mode of dying, such as cardiac or shock, or heart failure. List only one cause on each lins.													ratory arr	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel disease or condition		1	00	100	ر ا سا	1711	ort							Onset and Death
	resulting in death)											6MIN			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of): Conduction Condition of Conduction Conduction (Conduction Conduction) Due to (or as a consequence of): Conduction Conduction of Conduction Conduction (Conduction) Sequentially list conditions Due to (or as a consequence of): Conduction Conduction (Conduction) Sequentially list conditions												Sim		
CERTIFICATION	Sequentielly list conditiona,		DUE TO	(OR AS A	CONSEC	UENCE O	D: //C								29'3
Ă	if sny, leading to immediate cause. Enter UNDERLYING			(Silvipe it		0.000	*								
트	CAUSE (Disease or Injury that initiated events	1 "	DUE TO	(OR AS A	CONSEC	UENCE O	F):								
토	reaulting in death) LAST	d.													
	PART II. Other algnificant co	anditions :		d- oth h-		- total									
SAL	Anne	1 M	a lo	MAD.	it not re	euiting	in the und	derlying	ceuse g	iven in i	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	11016	MI C	13 110	100							_	1 🗆 YES 🤰	(X)NO		OF DEATH?
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PHYSICIAN: MEDIC	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDITED TO M		SUIE IO CA			_	H (Check o		UNC	ERTAIN	XX				
ĕ I	EXAMINER?	F	IOSPITAL:				QTHER	:							
¥	27. MANNER OF DEATH		Inpetiant 2 =		itlant 3	28b. TIM	X4.X Nursi	ng Home		sidence		er (Specify) SCRIBE HOW II			
	XX Natural 5 Pendi		(Month, Di				URY	WO		I NO	286. DE	SCHIBE HOW II	NJURY OCC	CURED	
B	2 Culate	tigation	28a. PLACE OF	FINJURY	— Al hor	ne, farm, a	street, facto			, 100	201 1 00	CATION (Street a	and Mumbar	or Duml C	Access Afrondos
	4 Homicide 8 Could		building,	atc. (Speci	(V)	,		. ,,			City	or Town, State)	nu number	or norer n	oute Number,
COMPLET	29e. CERTIFIER VIVI CERTIFICATION	O BUVOIO									_				
₹ I	29e. CERTIFIER XX CERTIFYIN one) 2 MEDICAL 8	EXAMINER:	On the basis of as	my knowle	end/or in	th occurre	of at the tin	ne, data	and place,	and due	to the ca	use(s) and man	nor ee state	ed.) and manner as stated.
	291 SIGNATURE AND TITLE OF					- Tooligatio		mnon, de				s and prace, an			
BE	Tellen	WIL	canl	w	つ				290 LICE	NSE NUM	BER 1				(Month, Day, Year) 6-95
2	30. NAME AND ADDRESS OF PER	SON WHO C	OMPLETED CAUS	F OF DEA	TH OTEN	27) (Time	(Print)		1	204		4		10-1	0-90
	IREDELL W.	IGLE	HART I	II,	M.D			.UN	IVE	RSII	Y F	KWY.,	BAL	0.M	ID. 21210
	31. DATE FILED (Month, Day 1995 22. HEGIST AR'S ST ATURE)														

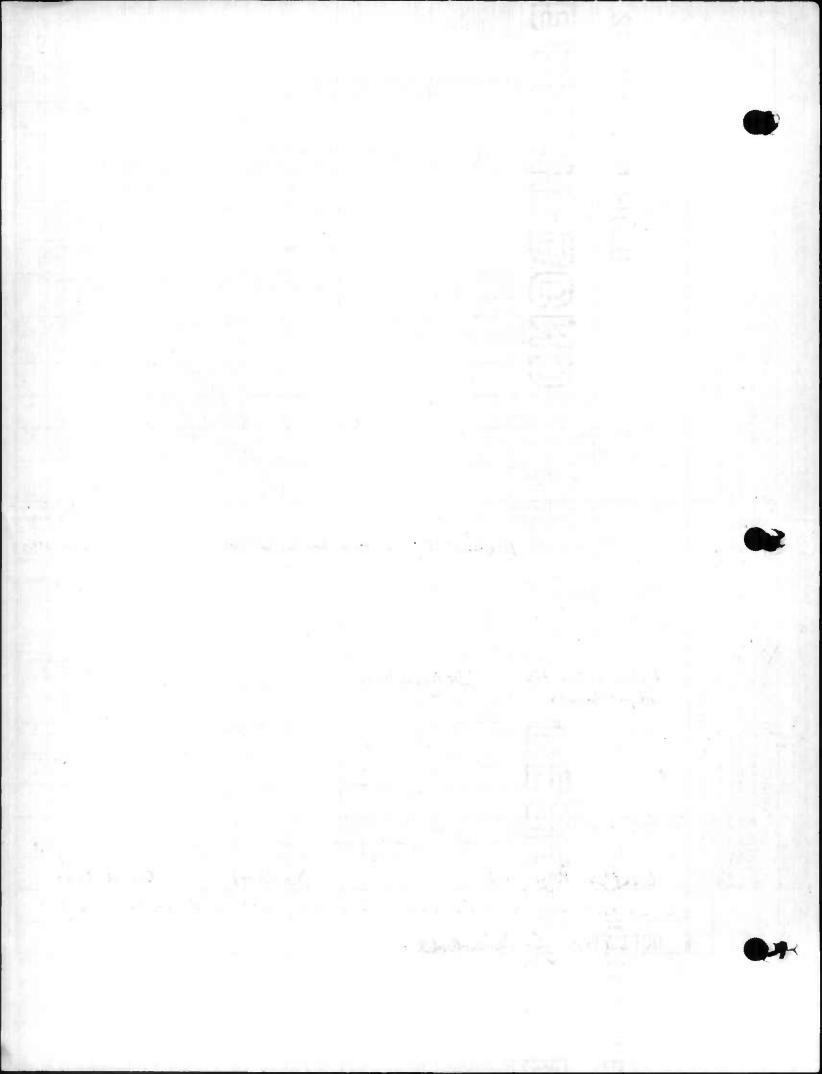
RE, MARYLAND 21215-0020

BALTIMORE, MARYLANI	ours after death. Page 6 may be retained by the hos	ly iffied in by the funeral director, page 5 should be detache ation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely miled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF V	TO THE HOSPITAL OR ATTENDING PHYSICIAL	TO THE FUNERAL DIRECTOR: After this certifit be filed within 72 hours after death with the	IMPORTANT: If item 28 is marked, or

1	FOR STATE REGISTRAR			STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1.	DECEDENT'S NA	ME (First	Middle, Last)		2. DATE OF DEATH
	Rose	Α.	Ferry	7	October 1

	Rose A. Ferry				2. DATE OF DEATH	DAY	YEAR 3. TIME OF DEATH				
		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	October		BIRTHPLACE (State or Foreign				
	170 00 0105		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)				
	9e. FACILITY NAME (If not institution, give street end number)		9b, CITY, TOWN	OR LOCATION OF DE	8/7/1		Ireland TY OF DEATH				
DIRECTOR	Meridian Nursing Cente	r	Cato	nsville		Bal	timore				
REC	10a, STATE 10b. COUNTY	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									
<u></u>	Maryland	Ba	altimo.	re, Mar	yland		LIMITS? 1 YES 2 NO				
3AL	10e. STREET AND NUMBER	f. ZIP CODE			EN OF WHAT COUNTRY?						
FUNERAL	4429 Manorview Rd.	21229			JSA						
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	3 2 NO	If yes, s	CENDENT OF NISPAN secify Cuban, Mexica 3 2 NO Specify		Ves or No	I4. RACE — American Indien, Bleck, White, etc. Specify: White				
6	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF I	BUSINESS/INDU	STRY				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Ille. Do NOT use		ost or working							
MP	12th Grade No	Cas	shier		ACME :	Supern	narket				
8	17. FATNER'S NAME (First, Middle, Last)				ME (First, Middle, Maid						
BE	John Ferry				ne Galle						
5	190.INFORMANT'S NAME (Type/Print) Veronica Moran Parr				imore, I						
		Db. PLACE AND DATE O									
	The state of the s	emetery, crematory or other dowrice			8/95		Sey, Maryland				
	21. SIGNATURE OF FUNERAL SERVICEMENSEL										
G. Truman Schwab G. Truman Schwab Schwab											
CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of):										
CER	d										
	PART ii. Other algnificant conditions contributing to death	1 1.4		g cause given in	Part i. 24e. WAS	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
MEDICAL		engrato	m		1 TYES	2 NO	COMPLETION OF CAUSE OF DEATH?				
ME	Depression	<u> </u>			3 10 3	/	1 TES 2 NO				
AN.	07 W00 0.00 PFFFPPPP TO WEDGE										
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 SK NO 1 noestlent 2 R/Os		OTHER:	LACE OF DEATN (Chi							
PHYSICIAN	1 YES 2 DE NO 1 Inpetient 2 ER/OL 27. MANNER OF DEATH 28e. DATE OF INJUR			DURY AT	6 Other (Specify) 28d. DESCRIBE NO	W INJURY OCCI	IBED				
	1 Natural 5 Pending (Month, Day, Year	INJU		YES 2 NO							
TED BY	2 Decident	RY — At home, farm, at secily)	reet, factory, offi	20	281. LOCATION (Stre City or Town, Ste	et and Number c	v Rural Route Number,				
COMPLET	29a. CERTIFIER 1 CERTIFVING PNYSICIAN: To the best of my kno	pyledge deeth secure	d at the time dat	and place and div	to the assertation of						
ME	(Check only one) 2 MEDICAL EXAMINER: On the basic of examiner										
	29b. SIGNATURE AND TITLE OF CENTIFIER			29c. LICENSE NUN			SIGNED (Month, Day, Year)				
TO BE	Guether Rya MA 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF			1275	41	► Oc	-21227				
	GEETHA RAJA 4367		Ferry	Rd Bas	ltimore	MD.	-21227				
	31. DATE FILED (Month, Day, Year) OCT 1 7 1995 Juli Studio	SNATURE									





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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wing. It hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use he find within 20 hours after death with the State Dent of Health and Mental Horlege prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH Helen R. Gorsuch HELEN RITA GORSUCH 16, 1995 07:45 am October 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign May 16,1919 DAYS 1 - M 2 X F 220-24-8669 Pa. 76 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Union Memorial Hospital DIRECTOR N/A Baltimore City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland N/A Baltimore City 1 X YES 2 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5108 Eugene Ave. 21206 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried specify White 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Practical Nursing Nursing 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) John Luschinsky Justine Unknown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. William H. Gorsuch 5108 Eugene Ave. Baltimore, Maryland 21206 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 20e. METHOD OF DISPOSITION

| Burlel 2 | Cremetion 3 | Red

4 | Donation 6 | Other (Specify) | Parkwood Cemetery Oct. 19,95 Parkville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE SEFFREY L. Gair Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 Enter the discusse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death IMMEDIATE CAUSE (Finel disease or condition___ - Schemic Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF): Ischemic 5 years resulting in death) Heart Disease Atherosclerotic
DUE TO (OR AS A CONSEQUENCE OF): 5 years CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAIL ARLE PRIOR TO Hypertension, Insulin-dependent diabetes, COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO Peripheral Vascular Disease 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO NOSPITAL: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident
3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check only one)

One)

MEDICAL SYMMER. On the best of my knowledge, death occurred at the time, date end place, end dua to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beels of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Julie E. E. Kuperomith, MD 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8.8. Doctober 16, 1995 AT 2438946-88 2

Union Memorial Hospital

32. DEGISTRAR'S SIGNATURE

E. E. Kupersmith, m.D Julie 31. DATE FILED (Month, Day, Year) OCT1 71995

DHMH-16 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE	STATE OF MARYLAND /	DEPARTMENT OF I			_						
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	CE	RITFICATE OF	DEATH	REG. NO	D.	3. TIME OF OEATH					
	RASHID	AWWAN	GRIFFI	VĪ.	MONTH		AR					
	4. SOCIAL SECURITY NUMBER 217-08-4409	5. SEX 6. AGE (In yrs. lest		IF UNDER 24 HRS. HOURS MIN.	OCT. 1 7. DATE OF BIRTH (Month, Qey, Year) April (U		BIRTHPLACE (State or Foreign Country)					
TOR	99. FACILITY NAME (If not institution, give street and number) GREENS LANE AND GREENMEAD RD. RANDALLSTOWN BALTIMOF RESIDENCE OF DECEDENT											
DIRECTOR	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10c. CITY, TOWN OR LOCATION 11											
FUNERAL	3237 Southgreen Rd 101. ZIP GODE 244 109. CITIZEN OF WHA											
В	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.ARMED FORCES? 1 VES 2 NO 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S.ARMED FORCES? 1 VES 2 NO If yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — / Bleck, WP Specify:											
ED	15. DECEDENT'S EDUC (Specify only highest grade		CEDENT'S USUAL OCCUPATI		16b. KIND OF BI	JSINESS/INDUST	TRY					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trapher's NAME (Eirst, Middle, Last) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use refined.) The property of the prope												
BE CO	17. FATHER'S, NAME (First, Middle, Last). 18. MOTHER'S NAME (First, Middle, Maiden Surmarne) 19. HOTHER'S NAME (First, Middle, Maiden Surmarne) 19. HOTHER'S NAME (First, Middle, Maiden Surmarne)											
TO B	190. INFORMANT'S NAME (Specificini)	Griffin 190	MAILING ADDRESS (Street 50)	and Number or Rural why ree	Route Number, City or To	Rando	10 1 stown, md					
	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ram 4 Donation 5 Starter (Specify)	oval from State 200 ALACEA cornellary, cre	melory of other place) MP	m. Pk	DATE 20c. L	Arbh	or Town, Stata					
	21. BROWNATURE OF FUNDERAL SERVICE LIC	Chron	man	ND ADDRESS OF FA	F-west	le						
	23. PART I. Enter the diseases, or o	complications that caused the de List only one cause on each line.	ath. Do not anter the me	ode of dying, suc	ch as cardiac or rea	piretory arrest	Approximate Interval Between					
	IMMEDIATE CAUSE (Final	a. GUM HOT W.		5DUL			Onset and Dasti					
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEC	DUENCE OF):									
- T.	PART II. Other significant condition	is contributing to death but not r.	asulting in the underlying	g cause givan in	Part I, 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS					
PHYSICIAN: MEDICAL					PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
-	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	TH YES NO E	UNCERTAL	Ν□							
M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (Check only one									
SIC	1X YES 2 □ NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	□ DOA 4 □ Nursing Hor	ne 5 🗆 Realdenca	8X Other (Specify)	AT SCE	ENE					
ВУ РН	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. IN	JURY AT ORK?	28d. DESCRIBE HOW	INJURY OCCUR	ED					
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At hol building, atc. (Specify)		:0	28f. LOCATION (Stree City or Town, Stet	(e)	Rural Route Number,					
COMPLETED	and and	ICIAN: To the best of my knowledge, de ER: On the basis of examination and/or i	eth occurred at the time, dat		to the cause(a) and m	anner as stated.						
TO BE	Mousite Me	Yhell		O.C.M.			• 13, 1995					
-	38. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE OF DEATH (ITEL	M 27) (Time Print)									

111 Penn Street, Baltimore, Maryland 21201

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HARGPMON A. WWW. 111 Penn St

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within—K hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

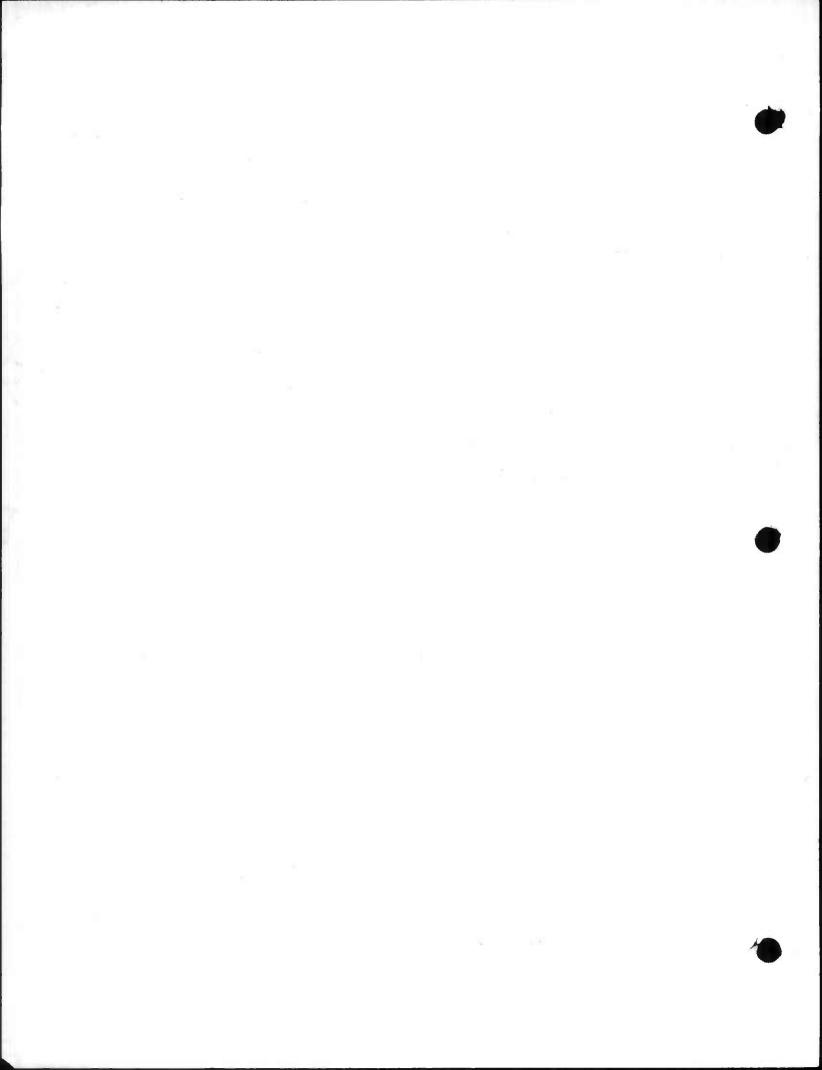
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
	JOS.		Α.	GUER	IN					OCTOBER 15. 1995			5.42 P M	
	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF I			8. BIRTH Count	IPLACE (State or Foreign
	057-14-0787		1 🔀 M 2 🗆 F	76	YRS.	MONTHS	DATE	HOURS	Miller,	7-18-			73.00	York
· ·	9a. FACILITY NAME (If not ins	titution, give s	treet and number)			9b. CITY	TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	NTY OF D	EATH
힏	GREATER BAL	TIMORE	E MEDICAL	CENTE	R	1 7	OWS	ON				R7	TTT	MODE
DIRECTOR	10a. STATE	10b. COUNTY				ry, town o	R LOCA	TION						10d, INSIDE CITY
붑	Maryland	Balt:	imore		Lu	ther	rill	е						LIMITS?
AL	10. STREET AND NUMBER	D	2				101	ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	8404 Elliso	n Road	a				2109	3		21693 H.C.			II S. A.	
Į.	11. MARITAL STATUS 1 Never Married 2 7 h		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	MAS DEC	ENDENT (OF HISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACI	E — American Indian, k. White, etc.
B	3 Widowed 4 Divor		IF YES, GIVE V	YES 2				2 NO			11, 410.7		Spec	lly:
	15, DECE	DENT'S EDU	CATION	WWII	DECEDENT'S	LIISHAL O	CLIDATI	OM		10h KII	ID OF BUS	INFOCUAL	Wh:	ite
	(Specify only Elementary/Secondary (0-1	highest grade	completed) College (1-4 or 5		(Give kind of life. Do NOT u	work done	during mo	ost of working	ng	100. 101	ID OF BOS	INESS/IN	JUSTRI	
IP	12		conege (1-4 of 5		count	ant				S	teel			
COMPLETED	17, FATHER'S NAME (First, Mid	idie, Last)						18. MOT	HER'S NAI	ME (First, Midd	le, Maiden	Sumame)		
BE	Joseph		A.	Gueri	n			L	illia	an			Brus	sh
6	19a. INFORMANT'S NAME (Ty)									loute Number, (City or Town	, State, Zip	Code)	
	Mrs. Helen		n _A		same		_		0±					
	20a. METHOD OF DISPOSITIO	3 Rem	fred from Gata	20b. PLAC	CE AND DATE crematory or 4	OF DISPOS	ITION (No		10 10	DATE		CATION —		
1 St Burlat 2 Cremation 3 Remote from the Commettery, crematory or other place) 4 Doneston 5 Other (Copy) 21. Signature of Funeral Structure of Funeral Str										٨.				
22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc.														
- 2	Erngs+	1 tex	St. III			10)50	York	Rd.	, Tows	on, l	Md. 2	21204	4
	23. PART I. Enter the dis	eeses, og e art fallure.	fomplicetiona the List only one ceu	t coused the use on each I	death. Do	not enter	the mo	de of dy	ing, suct	ss cerdiac	or reapl	ratory sri	rest,	Approximata Interval Batween
IMMEDIATE CAUSE (Final											Onset and Death			
	resulting in death)	•	a. pres	OR AS A CON	ta	ulu	7							
_		_	1			r):								
CERTIFICATION	Sequentially list conditions, if smy, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												-	
§	cause. Enter UNDERLYIN CAUSE (Disease or Injur	IG	C	•										
E	that initiated events resulting in death) LAST		DUE TO	(OR AS A CON	SEOUENCE O	F):								
H	readiting in death) LAST		d											·
	PART il. Other significen	t condition	a contributing to	death but no	t resulting	In the un	derlyin	g cause (given in	Part i. 24	. WAS AN		24b	. WERE AUTOPSY FINDINGS
EDICAL	Penal	Jaul	me)							_ 1	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME		0										F14.0		OF DEATH? 1 YES 2 NO
_	DID TOBACCO US	E CONTR	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗆 1	10 C	UNC	ERTAIN	12				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. Pt	ACE OF DEA									
YSI	1 TES 2 NO		1 Inpetient 2	ER/Outpatient	3 🗆 DOA	OTHER 4 Num		10 5 □ Ra	sidence	6 Other (Sp	ecify)			
F	27. MANNER OF DEATH 1 Natural 5 P	andina	28a. DATE OF (Month, D	INJURY lay, Year)	28b. TIN	IE OF JURY	28c. INJ WO	URY AT		28d. DESCRI	BE HOW IN	JURY OC	CURED	- 6
B	2 Accident In	vestigation				М		YES 2	NO					
ED		ould not be etarmined	building,	etc. (Specify)	nome, tarm,	street, fact	ory, offic	•		281. LOCATIO City or To	N (Street a wn, State)	nd Number	or Rural F	Route Number,
	29a, CERTIFIER											_		
COMPLET			CIAN: To the best of) and menner as stated.
	29b. SIGNATURE AND TITLE (1	ABITHITIAL TOTAL AND	Or IIIVestigatic	on, in my o	риноп, а				place, and			
290. DATE STORED (MOTIO, DW) THAT										(Month, Day, Year)				
2	30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAU	SE OF DEATH (I	TEM 27) (Type	, (P7hug)	_						0116	14
	30. NAME AND ADDRESS OF	EPA				Pier	nc 1	h.	كننلأ	€ 50	7	SCOV	V L	HOSIS JA
	OCT 1 7 199			R'S SIGNATURE										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat. cremation, or removal.

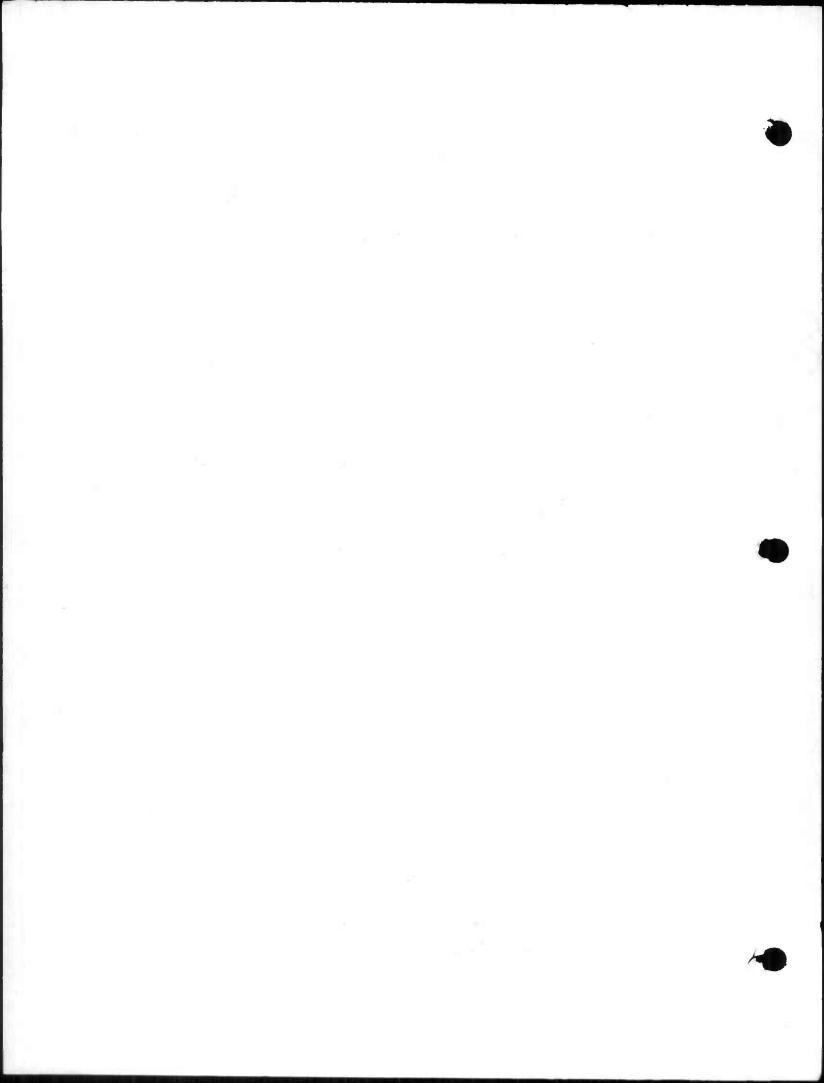
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				T DEALH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATH DA	γ ,	3. TIME OF GEATN	
- 1	Prane Gudauskas								
- 1	4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (/	In yrs. last birthday)	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	7. DATE OF BIRTN	8	BIRTNPLACE (State or Foreign	
~	215-30-4393	M 2 🕟 F	78 YRS.	MONTHS DAY	rs HOURS MIN.	Feb. 21,	1017	Russia	
	9a. FACILITY NAME (If not institution, give street a	21	70	AL OUT Y TOY	VN OR LOCATION OF DI				
		21	227			EATH	9c. COUNTY OF GEATN		
DIRECTOR	1258 Poplar Avent	ue Arbutu	ıs	Arb	utus		Baltimore		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CIT	Y, TOWN OR LO	CATION		-	10d, INSIDE CITY	
		mara		butus				LIMITS?	
	-	more	AL	bucus				1 TES 2 NO	
4	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF V								
ᇤ	1258 Poplar Ave	nue			21227		Unit	ed States	
FUNERAL		WAS DECEDENT EVER IN			OECENOENT OF NISPAI	NIC ORIGIN? (Specify Yes	or No — 1	4. RACE — American Indian, Black, White, afc.	
	I C HOLD MALLOO TO ES SMOTHER	FORCES? 1 YES	ATES X NO		YES 2X NO Specif			Specify:	
В	3 Widowed 4 Divorced							white	
<u> </u>	15. DECEOENT'S EOUCATIO (Specify only highest grade comp	ON .	16a. DECEDENT'S	USUAL OCCUP	PATION a most of working	16b. KINO OF BUS	INESS/INDU	STRY	
ETED		ollege (1-4 or 5+)	life. Do NOT us	e retired.)	g most or working				
4	12		seams	tress		garme	ent		
COMPL	17, FATHER'S NAME (First, Middle, Lest)		beamb	01 000	ress carment				
-		110			022	Cnible	,		
8	longinas Petru	112		400000000000		Snitko Route Number, City or Town	- O 71- C		
0								21227	
	Kazys Gudauskas					e Arbutus			
	20a. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal:	from State con	PLACE AND DATE O		N (Name of	DATE 20c. LO	CATION — CI	ity or Town, Stata	
	4 Donation 6 Other (Specify)	Me	etro Cr	emato	ry	10/18 Cat	onsy	rille, Maryla	
- 1	21. SIGNATURE OF PHIESPAL SERVICE LICENSE	EE			E AND ADDRESS OF FA	CILITY			
	- 1M17			Amb	rose Fun	eral Home	e, In	c. Arbutus	
_	23. PART I. Enter the diseases, or comp	au		132	8 Sulphu	r Spring	Road	at, Approximate	
	shock, or heart fellure. List	only one couse on e	sch line.	not enter tha	mode or dying, aud	n aa cardiac or respi	ratory arre	Interval Between	
	resulting in death) - a. CONGESTIVE HEART FRITTIE 212mg								
		DUE TO HOR AS A	CONSEQUENCE OF	F):	10 .				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Condestive Heart Failure Due to whas a consequence of): Coronary Artery Disease Due to (or as a consequence of):								
2		Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							
NO	Sequentially list conditions,	DUE TO (OR AS A	COASEQUENCE OF	.)	1 1				
ATION	cause. Enter UNDERLYING	Mitra (COASEQUENCE OF	101.	tetion)		71211-1	
FICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A DUE TO (OR AS A	1ce 4	10/. ·	tetiur)		71211-5	
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	1-11-12	1ce 4	10/ · ·	tetion)		71211-5	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	1-11-12	1ce 4	10/. ·	tztiur)		71211-5	
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	A CONSEQUENCE	F):	T2 + (6 /	Part I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS	
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE	F):	T2 + (6 /	Part I. 24a. WAS AN PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
EDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE	F):	T2 + (6 /	Part I. 24e. WAS AN	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
EDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions co	DUE TO (OR AS A	A CONSEQUENCE O	F):	T2T(6/	Part I. 24a. WAS AN PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
EDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on DID TOBACCO USE CONTRIBUTIONS.	DUE TO (OR AS A	DUT NOT RESULTING	in the under	iying ceuse given ir	Part I. 24a. WAS AN PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
EDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions could be conditioned by the conditions condi	DUE TO (OR AS A DONTRIBUTING TO GENTLE)	OUT NOT RESUlting	In the under	lying ceuse given in	Part I. 24a. WAS AN PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
EDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions could be conditioned by the conditions condi	DUE TO (OR AS A DONTRIBUTING TO GENTAL:	OF DEATH YE	In the under	lying ceuse given in UNCERTAL one) Home 5 XRasidence	Part I. 24a. WAS AN PERFOR 1 VES 2	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
EDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions	DUE TO (OR AS A DONTRIBUTING TO GENTLE)	DUT NOT resulting DEF DEATH YE 26. PLACE OF DEATH Petient 3 □ DOA 280. TIM	In the under ES NC TN (Check only OTHER: 4 Nursing	lying ceuse given in UNCERTAL One) Home 5 Rasidence INJURY AT WORK?	Part I. 24a. WAS AN PERFOR	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions could be conditioned by the conditions condi	DUE TO (OR AS A DOITH TO CAUSE O OSPITAL: Inpetient 2 = ER/Outs 2 = ER/Outs 2 = ER/Outs	DUT NOT resulting DEF DEATH YE 26. PLACE OF DEATH Petient 3 □ DOA 280. TIM	In the under ES NC TN (Check only OTHER: 4 Nursing	lying ceuse given in UNCERTAI one) Home 5 XRasidence	Part I. 24a. WAS AN PERFOR 1 VES 2	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on the conditions of the co	DUE TO (OR AS A DOITH TO CAUSE O OSPITAL: Inpetient 2 = ER/Outs 2 = ER/Outs 2 = ER/Outs	DEPTH ACT OF DEATH	In the under In the under In the under In (Check only OTHER: A Unusing I C OF JURY M 1	dying ceuse given in UNCERTAL one) Home 5 Residence NURY AT WORK? YES 2 NO	Part I. 24a. WAS AN PERFOR 1 VES 2	NJURY OCC	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 00	
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	DUE TO (OR AS A DITTIBUTING TO GET TO CAUSE O OSPITAL: Inpetient 2 ER/Outs 26e. DATE OF INJURY (Month, Day, '6er') 28e. PLACE OF INJURY 28e. PLACE OF INJURY	DEPTH ACT OF DEATH	In the under In the under In the under In (Check only OTHER: A Unusing I C OF JURY M 1	dying ceuse given in UNCERTAL one) Home 5 Residence NURY AT WORK? YES 2 NO	Part I. 24a. WAS AN PERFOR 1 VES 2 N S Other (Specify) 28d. DESCRIBE NOW I	NJURY OCC	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 00	
ETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTED 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A DUTTIBUTION OF THE TO CAUSE OF THE CONTROL OF THE	DE DEATH YE 26. PLACE OF DEATH 26. PLACE OF DEATH No. 1 At home, farm, cify)	In the under In	tying ceuse given in UNCERTAL One) Home 5 Rasidence INJURY AT WORK? YES 2 NO	Part I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) 28d. DESCRIBE NOW 1 28f. LOCATION (Street City or Town, State)	NJURY OCCU	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,	
ETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO CAUSE O OSPITAL: Inpetian: 2 = EN/Outp (Month, Dey, Year) 28a. PLACE OF INJURY (Moling, etc. (Spe	DIT DEATH YE 26. PLACE OF DEATH 28b. TIM IN. 7 — At home, farm, city)	In the under In	deta and place, and du	B Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Yown, State) e to the cause(e) and me	NJURY OCCI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,	
ETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO CAUSE O OSPITAL: Inpetian: 2 = EN/Outp (Month, Dey, Year) 28a. PLACE OF INJURY (Moling, etc. (Spe	DIT DEATH YE 26. PLACE OF DEATH 28b. TIM IN. 7 — At home, farm, city)	In the under In	tying ceuse given in UNCERTAL One) Home 5 Residence NURY AT WORK? YES 2 NO office deta and place, and du on, death occured at the	8 Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) a fo the cause(a) and me e time, data and place, ar	NJURY OCCI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,	
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO CAUSE O OSPITAL: Inpetian: 2 = EN/Outp (Month, Dey, Year) 28a. PLACE OF INJURY (Moling, etc. (Spe	DIT DEATH YE 26. PLACE OF DEATH 28b. TIM IN. 7 — At home, farm, city)	In the under In	tying ceuse given in UNCERTAL One) Home 5 Residence NURY AT WORK? YES 2 NO office deta and place, and du on, death occured at the	8 Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) a fo the cause(a) and me e time, data and place, ar	NJURY OCCI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on the conditions of the co	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO CAUSE O OSPITAL: Inpetian: 2 = EN/Outp (Month, Dey, Year) 28a. PLACE OF INJURY (Moling, etc. (Spe	DIT DEATH YE 26. PLACE OF DEATH 28b. TIM IN. 7 — At home, farm, city)	In the under In	tying ceuse given in UNCERTAL One) Home 5 Residence NURY AT WORK? YES 2 NO office deta and place, and du on, death occured at the	8 Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) a fo the cause(a) and me e time, data and place, ar	NJURY OCCI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number, d. cause(s) and manner as stated.	
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on the conditions of the co	DUE TO (OR AS A DITTIBUTING TO GENTLE DITTIB	DEATH YE 26. PLACE OF DEATH 26. PLACE OF DEATH A thome, farm, city) A consequence 26. Time 18. Time 27. At home, farm, city) A thore of the court on and/or investigation 28. Time 28. Time 29. Time 29. Time 20. Time 20. Time 20. Time 20. Time 21. Time 22. Time 23. Time 24. Time 25. Time 26. Time 27. Time 27. Time 28. Time 28. Time 29. Time 29. Time 20. Time 29. Time 20. Tim	In the under In	tying ceuse given in UNCERTAI One) Home 5 X Rasidence NURY AT WORK? YES 2 NO office data and place, and du on, death occured at the 29c. LICENSE NU D 3 2	Part I. 24a. WAS AN PERFOR 1 YES 2 N	NJURY OCCI	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100 URED OF Rural Route Number, ed. cause(a) and manner as stated. SIGNED (Morith, Dey, Year) 2 1 6 9 5	
BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions of DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A DITTIBUTING TO GENTLE DITTIB	DEATH YE 26. PLACE OF DEATH 26. PLACE OF DEATH A thome, farm, city) A consequence 26. Time 18. Time 27. At home, farm, city) A thore of the court on and/or investigation 28. Time 28. Time 29. Time 29. Time 20. Time 20. Time 20. Time 20. Time 21. Time 22. Time 23. Time 24. Time 25. Time 26. Time 27. Time 27. Time 28. Time 28. Time 29. Time 29. Time 20. Time 29. Time 20. Tim	In the under In	tying ceuse given in UNCERTAI One) Home 5 X Rasidence NURY AT WORK? YES 2 NO office data and place, and du on, death occured at the 29c. LICENSE NU D 3 2	Part I. 24a. WAS AN PERFOR 1 YES 2 N	NJURY OCCI	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100 URED OF Rural Route Number, ed. cause(a) and manner as stated. SIGNED (Morith, Dey, Year) 2 1 6 9 5	
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions on the conditions of the co	DUE TO (OR AS A DITTIBUTING TO GENTLE DITTIB	DIT DEATH YE 26. PLACE OF DEATH 26. PLACE OF DEATH (T — At home, farm, city) At home, farm, city At home, far	In the under In	tying ceuse given in UNCERTAI One) Home 5 X Rasidence NURY AT WORK? YES 2 NO office data and place, and du on, death occured at the 29c. LICENSE NU D 3 2	8 Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) a fo the cause(a) and me e time, data and place, ar	NJURY OCCI	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100 URED OF Rural Route Number, ed. cause(a) and manner as stated. SIGNED (Morith, Dey, Year) 2 1 6 9 5	
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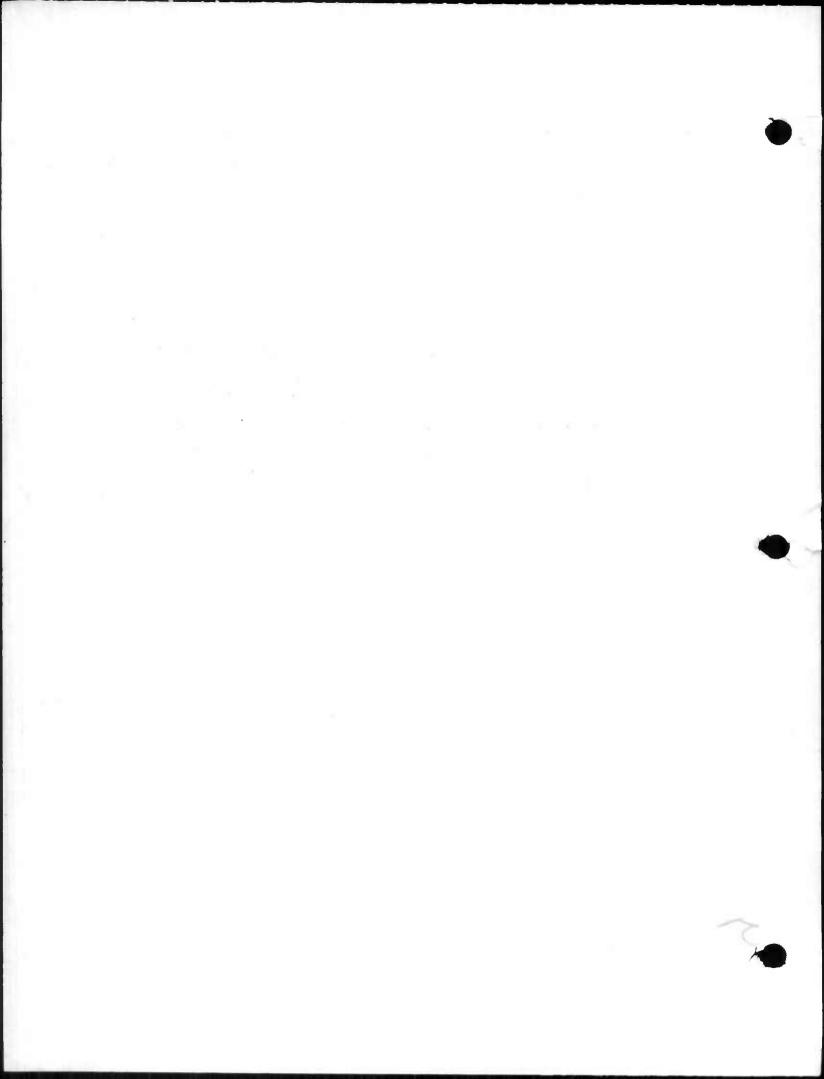


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an analysis of the hospital or attending physician. TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

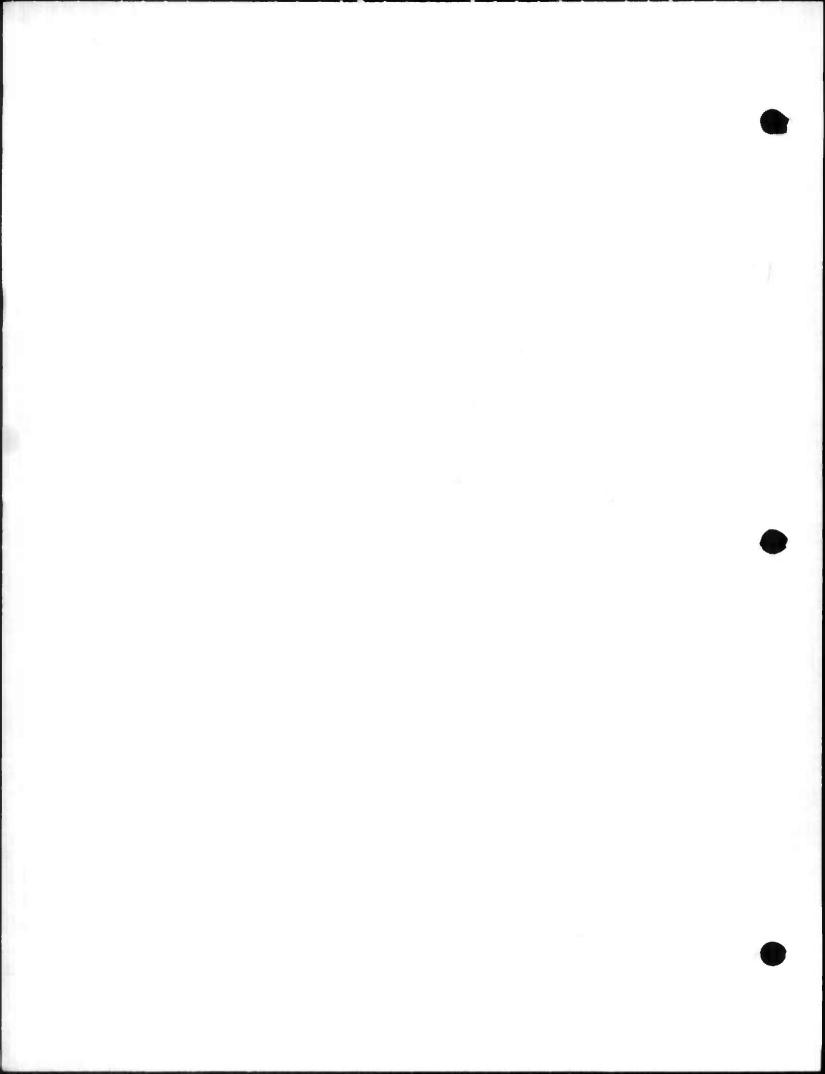
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 1 - FOR STATE REGISTRAR

_	negistran OEIIII I	PAIL OF BLAIT	HEG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) NAOM; Griffin		2. DATE OF DEATH DAY OCTO BET 13. 19	3. TIME OF GEATH 95 8:45 A.M				
	26-34-3551 10 M 2 BF 56 YRS. 11	IF UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	MAY 12,1939	BIRTHPLACE (State or Foreign Country)				
Dinector	9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOS PITAL	BALTIMOR	TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PALTIMORE					
	10a. STATE 10b. COUNTY 10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY				
	MD, N/A P	ALTIMORE		1 D YES 2 NO				
חשווח	5145 FREDERICK AVE.	2122	9 4	of what country?				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARIMED FORCES? 1 YES 2 1.000	If yes, specify Cuban, Mexica		4. RACE — American Indian, Black, White, etc.				
2	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	1 TYES 2 NO Specifi		BLACK				
	life Do NOT use	rk done during most of working	16b, KINO OF BUSINESS/INDU	STRY				
CMPLE	Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) ACCOUN	VIANT CLER	X H0591/1	4				
200	17. FATHER'S NAME (FIRST, MIDDIO, LISS) STANLEY PRISCOE	18. NOTHER'S NA	ME (First, Middle, Maiden Surname)					
5	190. INFORMANT'S NAME (Type/Print) TRUENTO SILLING A TRUENTO SILLING A	DDRESS (Street and Number or Rural FREDERIC)	Route Number, City or Town, State, Zip C	WID. 21229				
	20a. METHOD OF DISPOSITION 1. Buriel 2 Crewfitton 3 Removal from State 4 Donastion 5 Other (Specify)	DISPOSITION (Name of prolace)	DATE 20c. LOCATION — CI	Ity or Town, State				
	21. SIGNATURE OF PINETIAL SERVICE LICENSES	22. NAME AND ADQUISES OF EA	MACH FUNGRAL	Homs V.A.				
	· Court March	270 FRED	HILTON PASS P	MITI.MD.21229				
	23. PART i. Enter the diseases, or complications that caused the deeth. Do no shock, or heert fallure. List only one cause on each line.	t enter the mode of dying, suc	th as cardisc or respiratory street	Interval Between				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) one metastatic breat cancer one metastatic breat cancer							
	e. OUE TO (OR AS A CONSEQUENCE OF):	e wit (e)						
NO IN	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):							
5	CAUSE (Disease or Injury							
	that initiated events reaulting in deeth) LAST							
7	PART II. Other algorificant conditions contributing to deeth but not resulting in	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
3		PERFORMED?	COMPLETION OF CAUSE OF DEATH?					
N N			1 - YES 2 - 410					
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
SICIAIN	25. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one)							
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Netural 5 Pending	OF 28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCL					
100	2 Accident Investigation 3 Suicide 6 Could not be building, etc. (Specify)	1 123 2 10	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
EIED	4 Homicide determined							
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.							
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D					
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
	YVINNE OTTAVIANU GOO CATON AVE BALTIMORE MD 21229							
	31. DATE FILED (Month, Day, Your) OCT 1 71995 July Division 12. REGISTRAR'S SIGNATURE							
_								



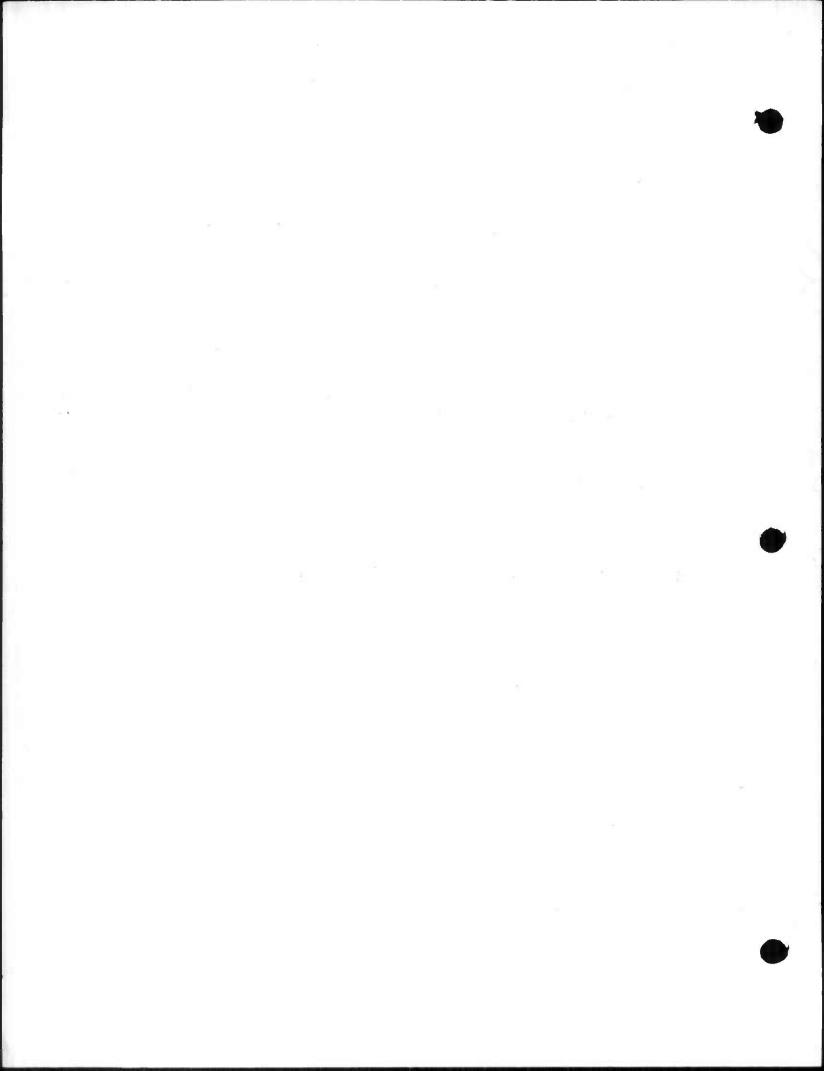


7 18	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF DEA	I. NO.	3. TIME OF DEATH
	William Frederic					Octobe	r 02, 19	95 M
8	Col. A Colored In Colored Co.		(In yrs. lest birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Y 10-10-	ber)	B. BIRTNPLACE (State or Foreign Country) Colorado
стов	9a. FACILITY NAME (If not institution, give stre Manor Care-Ruxto)			96. CITY, TOWN &	OR LOCATION OF E	EATN	9c. COUN	TY OF DEATN
DIREC	RESIDENCE OF DECEDENT 100. STATE Maryland Baltin	more		r, town or Local thervill				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 11111 Greensprin	g Avenue		10	1. ZIP CODE 21093		10g. CITIZ	EN OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES 1 YES GIVE WAR OR D 1 0-1942 TO	2 NO	If yea, sp		NIC ORIGIN? (Spec an, Puerto Rican, e fly:		14. RACE — American Indian, Black, White, etc. Specify: White C
LETED	15. DECEDENT'S EDUCA (Specify only highest grade oc Elementary/Secondary (0-12)		(Give kind of life. Do NOT u		ON ost of working		of Business/INDU	STRY
COMPI	12 17. FATHER'S NAME (First, Middle, Last) Alexander G. Ger		Psychi	uci, si	18. MOTNER'S N.	AME (First, Middle, A		
TO BE	190. INFORMANT'S NAME (Type/Print) Rose Gerringer	(wife)		ADDRESS (Street a	and Number or Rural	Route Number, City	or Town, State, Zlp (
1	20a. METHOD OF DISPOSITION 1		D. PLACE AND DATE netery, crematory or o	OF DISPOSITION (Ne			IC. LOCATION — C	, Maryland 2109 ty or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICENTAL B. 18	SEE Joseph B.	VanSant	State		Board-6		eltimore Street 21201-1559
	23. PART I. Enter the diseases, or conshock, or heart failure. Li	mplications that cause at only one cause on e	d the death. Do i	not enter the mo	oda of dying, aud	ch as cardiac or	reapiratory arre	Approximate Interval Between
	immediate cause (final disease or condition resulting in death)	Uru	A CONSEQUENCE O	Sepse	2			Onset and Dauth
NO	Sequentially list conditions, b.	185	v 35	Par	leusous	De	van	5 40
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							
CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):						
EDICAL O	PART II. Other aignificant conditions	contributing to death b	out not resulting	In the underlying	g cause given in		RFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	OF DEATH YE	S 🗆 NO 🗆] UNCERTAI		A	OF DEATH? 1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA					
PHYS	1 YES 2 NO 1	26a. DATE OF INJURY	petient 3 DOA	Nursing Nom		6 Other (Specific	() NOW INJURY OCCL	BED
ВУ Р	1 Return 5 Pending Investigation	(Month, Day, Year)	INJ	M 1 1	PRK? YES 2 NO			
ETED	3 Suicide 6 Could not be 4 Nomicide datarmined	26a. PLACE OF INJURY building, atc. (Spec	city)	street, factory, offic	•	261. LOCATION (S City or Town,		r Flural Route Number,
COMPL	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:							I. cause(s) and manner as stated.
BE C	290. BIGNATURE AND TITLE OF CONTIFIER	la M	9		29c. LICENSE NU	MBER 2990	29d. DATE	SIGNED (Month, Day, Year)
2	10. NAME AND ADDRESS OF PERSON WHO		17.5					



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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 mil	TO THE FUNERAL DIRECTOR: After this certificate has been stoned by the attending physician and completely filled in by the tringeral directory

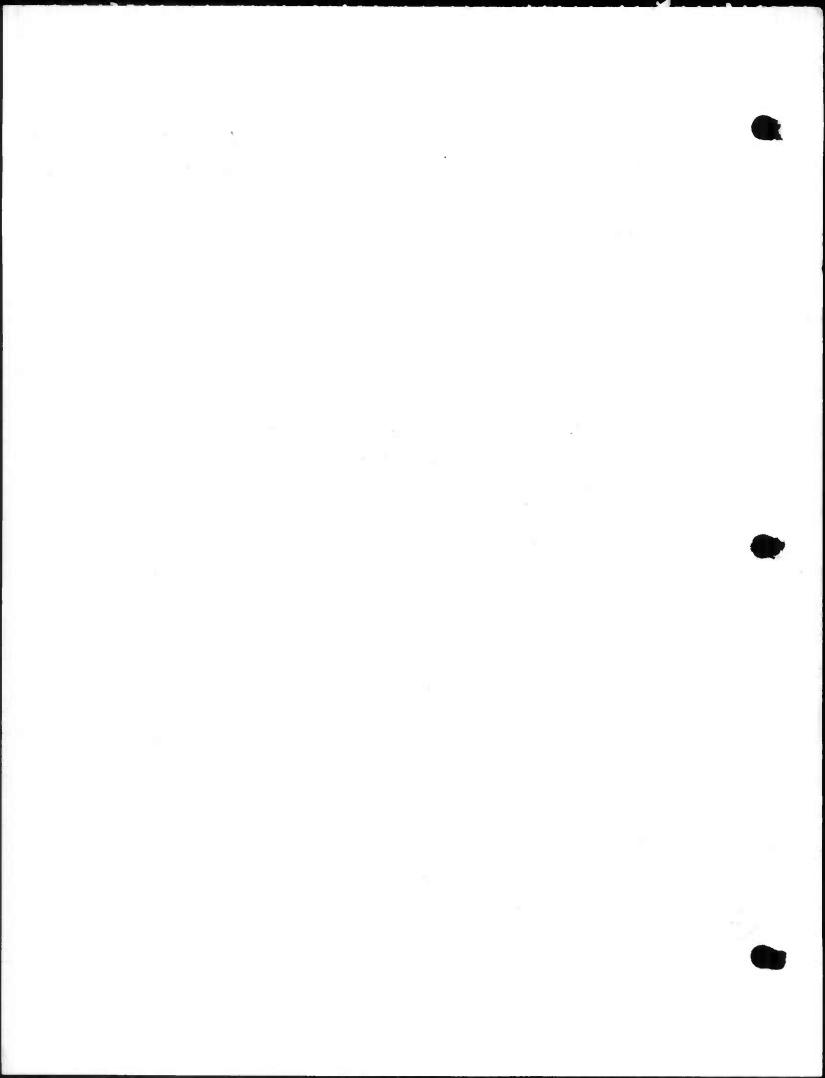
	1 - FOR STATE OF M. STATE OF M.		MENT OF HEALTH AI	ID MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Lest) Nathan	Graf	(GRAFTON	mouth.	DAY YE			
	4. SOCIAL SECURITY NUMBER 705-05-2888 XX M 2 F	93 YRS.		(Month, Day, Year) 06-18-	02 1	HRTHPLACE (State or Foreign country) MARYLAND		
TOR		PITAL	9b. CITY, TOWN OR LOCATION BALTIMOR		9c. COUNTY	N/A		
DIRECTOR	MARYLAND 10b. COUNTY N/A	10c. CITY,	TOWN OR LOCATION BALTIMOR	E CITY	\c	10d. INSIDE CITY LIMITS? XX YES 2 \(\square\) NO		
FUNERAL	1700 MERIDENE DRIVE			239	υ.:	OF WHAT COUNTRY?		
B	11. MARITAL STATUS 1 Never Merried X2X Merried 3 Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	EVER IN U.S. ARMED YES XXNO R OR DATES	13. WAS DECENDENT OF N If yes, specify Cuben, N 1 YES N NO	SPANIC ORIGIN? (Specify to exican, Puerto Rican, etc.) specify:		RACE — American Indian, Black, White, etc. Specify: WHITE		
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	life. Do NOT use	ork done during most of working		RAIL 1	RY		
COMPLET	17. FATHER'S NAME (First, Middle, Lest) JACOB A. GRAFTON	1102		S NAME (First, Middle, Malde		NOAD		
TO BE	19e. INFORMANT'S NAME (Type/Print)		DDRESS (Street and Number or I	tural Route Number, City or To	own, Stefe, Zip Code			
	AMETHOD OF DISPOSITION AMBurlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF		DATE 20c I	OCATION CHY	or Town State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. J. R.		HENRY 4905 YORK	W. JENKIN	IS ANI	SONS		
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury	on eech line.	MMONIA	sepsis	piratory arrest,	Approximata Interval Betwee Onset and Dea 2 Weeks		
MEDICAL	PART II. Other algorithms conditions contributing to de tacky - brady Synthin	me, Modera	ute aorhisk	PERFO	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN 125. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:							
PHYSI	1 YES 2 NO 1 Inputient 2 127. MANNER OF DEATN 280. DATE OF IN	R/Outpatient 3 DOA 4	OF 28c. INJURY AT	28d. DESCRIBE NOW	INJURY OCCURE	0		
ED BY	2 Accident Investigation	NJURY At home, ferm, str	M 1 YES 2 NO	281. LOCATION (Stree City or Town, State	t end Number or Ru	irel Route Number,		
COMPLET	29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of m							
BE	295. SIGNATURE IND THE OF CERTIFIER).	29c, LICENSE		29d, DATE SIG	NED (Month, Day, Year)		
01	Ali Saifi Good Samaritan Hos	0, 5601 Luch	Raven Blvd,	Ballimore,	WD 21	235		
	OCT 1 71995 July 32 begis FAR	ALOUA .						



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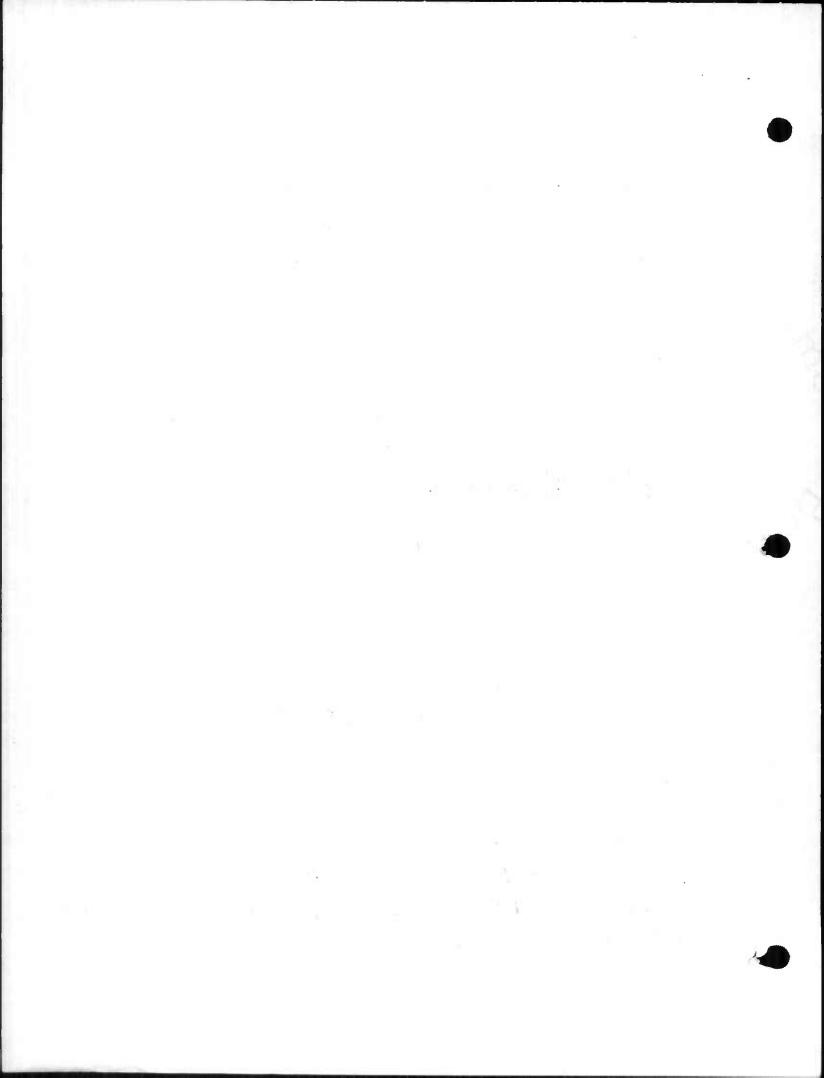
BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within minural after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ritedical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be southled at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART CERTIFIC			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	6:	Sperg					EAR 3. TIME OF DEATH
			7 -1 -1 -0	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	11 19	BIRTHPLACE (State or Foreign
	20-07-0100	M 2 F 88	YRS.	ONTHS DAYS	HOURS MIN.	Tuly 20	1907	MAN /AN
R	90. FACILITY NAME (If not institution, give street of LEVINDALE	and number)		BALTIM	OR LOCATION OF DI ORE	EATN /	N/A	OF DEATH
S	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY						<u> </u>	
DIRECTOR	MARYLAND N/A			TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS? XX YES 2 NO
3AL	100. STREET AND NUMBER 7201 BROOK CREST WA	V V V W W_]		101	ZIP CODE 21208			N OF WHAT COUNTRY?
JNE		WAS DECEDENT EVER IN I				NIC ORIGIN? (Specify Ye	USA	. RACE — American Indian.
BY FUNERAL	1 Never Married 2 Married	FORCES? 1 YES	2 VNO	if yes, sp	ecify Cuban, Mexica 2 NO Specifi	n, Puerto Rican, atc.)	O 140	Black, White, etc. Specify: WHITE
	IS. DECEDENT'S EDUCATION		NA. DECEDENT'S U	BUAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/INDI IS	
COMPLETED	(Specify only highest grade comp Elementary/Secondary (0-12) Co	oleted) ollege (1-4 or 5 +)		rk done during mo		CLOTHI		
MP.	11. 17. FATHER'S NAME (First, Middle, Land)		PACKLEY					
BE CC	MORRIS	HYMAN			TDA'S NA	ME (First, Middle, Maiden	Sumeme)	TUCH
TO B	184. INFORMANT'S NAME (Type/Frint)					Route Number, City or Tow		
550	MR. JOEL GINSBERG	206.8	3001 RO			OATE 20c. LO		21209
	1 Donation 5 Control (Specify)		SHE NIESI		10/12/95		OSEDAL	
	21. SIGNATURE OF FUHERAL REPRICE LICENSI	-		SO L	O AGORESS OF FA	SEN & BK	01	21215
	yey May	Louis						ctimace MO
	23. PART . Enter the diseases, or comp shock, or heart failure. List	only one cause on ago	tha death. Do no ch lina.	t entar the mo	da of dying, suc	h ss cardiac or reap	iratory srres	intarvai Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ASPIRAT	LON Pr	VEUM	oniA.			Onset and Death
	a	DUE TO (OR AS A C						
NO.	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):					
EA	cause. Entar UNDERLYING CAUSE (Disease or injury		-					
CERTIFICATION	that initiated eventa resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):					
	PART II. Other significant conditions co	intributing to death but	not resulting in	the underlying	a course gluon in	Part I, 24s. WAS AN	ALEXANDA	
ICAL	Multi Infa	rct Dene	ntia w	it du	Mhagia	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC	0				1 3		XIII	OF DEATN?
AN:	DID TOBACCO USE CONTRIBU		DEATH YES		UNCERTAIN	<u>ч 🗆 </u>		
SICI	EXAMINER?	OSPITAL: Inpatient 2 ER/Outpat	- 0	THER:	e 5 Residence	8 Other (Specify)		
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME (OF 28c. INJ		28d. DESCRIBE NOW I	NJURY OCCUP	ED
BĄ	1 Natural 5 Pending 2 Accident Investigation	28s. PLACE OF INJURY -	At home form str		ES 2 NO	204 1 2 2 4 7 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
COMPLETED	3 Suicide 6 Could not be 4 Nomicide determined	building, atc. (Specify)	ser, rectory, bine		281. LOCATION (Street City or Town, State)	end Number or	Hurili Houte Number,
PE		To the beat of my knowled	ige, death occurred	at the time, date	end piece, end due	to the cause(e) end me	nner se stated.	
COM		the beele of exemination of	end/or investigation,	in my opinion, d	eath occured at the	time, date end place, er	d due to the c	euse(e) end menner ae stated.
띪	296. SIGNATURE AND TITLE OF CERTIFIER	460m A7	TENDIN	1G	D 25			GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF OEAT	N (ITEM 27) (Type, P	int) SE'	у д S I	100	, ((0-11-95
	LEVINDALE 24 31. DATE FILEO (MONTH, Day, Year)		FLVER	DERE	AVENUE	BALTIM	ORE	MD 21215
		32. REGISTRAR'S SIGNAT						



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٠	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF HE		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	ADMINITED				2. DATE OF DEATH MONTH DA	W YE	3. TIME OF DEATH	
		ETTNER				OCT. 1	1.199	5 1:14 P	М
	4. SOCIAL SECURITY NUMBER 212-28-2112	14			IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) altimore Co.	
	9e. FACILITY NAME (If not institution, give stre			b. CITY, TOWN OR	LOCATION OF DE	Sept.4,19	9c. COUNTY		-
S S	HOPKINS BAYVIE	W MEDICAL	CENTER	BALTI	MORE C	ITY	Balt	imore City	
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CITY, 1	TOWN OR LOCATIO	N .	-		10d. INSIDE CITY	_
DIRECTOR	Maryland Balt	cimore		Kingsvi				LIMITS?	
AL	10e. STREET AND NUMBER			101. 2	CIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	7410 Goettner Ave				21087			.S.A.	
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IF	2 XNO	If yes, speci	Ify Cuben, Mexical	IC ORIGIN? (Specify Yes n, Puerto Rican, atc.)	or No.— 14.	RACE — American Indien, Black, White, etc.	
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	ATES	1 YES 2	NO Specify	:		White	
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	18e. DECEDENT'S US (Give kind of wor	BUAL OCCUPATION k done during most retired.)	of working	16b. KIND OF BUS	SINESS/INDUST	TRY	
P.E.	Elementery/Secondary (0-12)	College (1-4 or 5 +)	Self-Em			Goettner	Const	cruction Co.	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden			_
BE C	Frank C. Goettne	r			Paul	ine Schroe	eder		
0	190. INFORMANT'S NAME (Type/Print) Frank J. Goettnei	o In		ekord Ro		ston, Md.		de)	
	20e. METHOD OF DISPOSITION	20h	PLACE AND DATE OF					or Town, State	_
	1 XBuriel 2 Cremetton 3 Ramon 4 Donation 5 Other (Specify)		arkwood C		10/16/		timore		
	21. SIGNATURE OF FUNERAL SERVICE LICE	/			ADDRESS OF FA	n Funeral	Home		
	6.7.Ja	ssahn		1	Belair			, Md. 21087	
	23. PART I. Enter the diseases, or co shock, or heart fallure. L	omplications that cause ist only one cause on e	d the death. Do not ach line.	enter the mode	of dying, suci	h aa cardiac or reapi	ratory arrest	Approximata Interval Between	en
	IMMEDIATE CAUSE (Final disease or condition	MILLARD	LE INJ	UPIUS				Onset and Dea	ith
	reaulting in death)		CONSEQUENCE OF):	mrias					
N	Sequentially list conditions, b.								
ATIC	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						
FIG	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	reaulting in death) LAST								
AL C	PART II. Other significant conditions	contributing to death b	out not resulting in	the underlying	cause given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDING	GS .
000						1 XYES 2		COMPLETION OF CAUSE OF DEATH?	1
ME				en con det		′		1 YES 2 NO	
AN	DID TOBACCO USE CONTR	IBUTE TO CAUSE C	26. PLACE OF DEATH		UNCERTAIN	<u> </u>			
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:		OTHER:	5 Reeldence	5 Other (Specify)			
HA I	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJUF	RY AT	28d. DESCRIBE HOW I			
BY	1 Natural 5 Pending 2 Accident Investigation	10-11-015	1157/	M 1 YE	S 2 NO	10 A CU	or were	21	_
E	3 Suicide a Could not be 4 Homicide determined	building, etc. (Spe	cify)	eet, fectory, office		City or Town, Stete)	29K -111	AUTEN AUTON SA TION	12
LEI	29e. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	riedge, death occurred	at the time, date a	nd niece, and due	to the cause(e) and may	oner ee stated	RETOR DISTILL	4 P
COMPLET	2000							ause(e) and menner se stated.	
ш	200 THOMATURE AND TITLE ON CERTIFIER	X WW.			29c. LICENSE NUN	ABER	29d. DATE S	IGNED (Month. Day, Year) T. 12, 1995	_
TO B	mount &	max/			O.C.M.	E .	00	1. 12,1990	
1	MARIO F. GULL	ER W			, Balt	imore, M	aryla	nd 21201	
	0CT 1 7 1995 Jul	39. REGISTRAR'S SIGN	ATURE						



man and a second format of the	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cardificate be executed when the hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		iMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	deat	atte	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	7,
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH DAY MONTH.

i j	1. DECEDENT'S NAME (First, Middle, I	ast)							2. DATE OF DEATH			3. TIME OF DEATH
	GENE HAWKINS OCTOBER							2. 1	995	11:00 p m		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	-	8. BIRTH	PLACE (State or Foreign
	231-42-9092	1√1 M 2 □ F	61	YRS.	MONTHS	DAYE	HOURS	MAR.9, 1934 VIRGII			SINIA	
~	9a. FACILITY NAME (If not institution,				9b. CITY		OR LOCATE			9c. CO	JNTY OF DE	ATH
PDT:	1238 GL	ENHAVEN	ROAD			BAL	.TIMO	RE	CITY		n/a	
DIRECTOR	MARYLAND 106. CO			10c. CIT	Y, TOWN		TIMO	RE				10d. INSIDE CITY LIMITS? 1 XYES 2 NO
AL	10e. STREET AND NUMBER					10	f. ZIP COD	E		10g. CI	TIZEN OF W	HAT COUNTRY?
FUNERAL		VEN ROAD)				2	1239		UN	ITED	STATES
BY FUI	11. MARITAL STATUS 1)(X) Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. AF 1 YES 2 XX WAR OR DATES	NED NO		If yee, ap			IC ORIGIN? (Specify Yea n, Puerto Ricen, etc.)	or No-	14. RACE Black, Specify	- American Indien, White, etc.
ED	15. OECEDENT'S	EDUCATION	16a, DE	CEOENT'S	USUAL O	CCUPATI	ON		16b. KINO OF BU	SINESS/IN	OUSTRY	
COMPLETED	(Specify only highest : Elementary/Secondary (0-12)	College (1-4 or 5	- Illia	. Do NOT us	se retired.)	during m	ost of working	ng	CONCT	DUCT	TON	
MP	9 th	-		LAB0	KEK				CONST		TON	
	17. FATHER'S NAME (First, Middle, Last JAMES HAW	KINS						BEAT	ME (First, Middle, Maiden	Sumame))WLKE	2	
BE	19e. INFORMANT'S NAME (Type/Print)	KINS	10	h MAILING	ADDRES	C (Ctmat			loute Number, City or Tow			
2	LOIS E.	REVEL		48		16	th	STR	EET, N.E.,	WAS	HING	TON, D.C.
	20e. METHOD OF DISPOSITION 1X_XBurlal 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from Stata	20b. PLACE Cemetery, Cre KING				PARK				City or Tow	on, State 20017 WN, MD
	21. SIGNATURE OF FUNCAAL SERVICE	E LICENSEE	(Open				ND ADDRE		CILITY			
	1 Mil	ue/)	70n	60					H1101 E			AVENUE
	23. PART I. Enter the diseases, or compilerions that boused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Respurtory Approximate Interval Batween Onset and Death								Interval Batween			
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO								WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
Ä										AMO	- 1	OF DEATH?
ä	DID TOBACCO USE CO	NTRIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO [UNC	ERTAIN				
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT		-						
XS.	1 YES XX NO		ER/Outpatient 3	□ DOA	OTHER 4 Num	R: sing Hom	10 XX R	eldence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH 1 [X] Vietural 5 Pending	28a. DATE Of (Month, I	F INJURY Day, Year)	28b. TIM INJ	E OF URY	WC	URY AT	340	28d. DEŞCRIBE HOW II	NJURY OC	CURED	
B	2 Accident Investigat 3 Suicide & Could po	26a, PLACE I	DF INJURY — At ho	ma, farm, a	treat, fact		YES 2	NO	281, LOCATION (Street a	and Numbe	y or Rural Br	udn Blumbae
	4 Homicide 6 Could not determine	building	, atc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					City or Town, State)	and wante	o nos no	otto reambol.
COMPLETED		HYSICIAN: To the beet o										and manner se stated.
	29b. SIGNATURE AND TITLE OF CERT		11					NSE NUM				Month, Digit Hear)
8	10	Regh	Ha	u			7	22	2034	-	10/	16/55
임	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAL	SE OF DEATH (ITE	M 27) (Type,	Print)	C	AV	2 4 1	Riva	1	1	-/ /3
-	31, DATE FILED (Month, Day, Year)	32. REGISTR	AR'S SIGNATURE	NU	CII	1	-HV	N	10100			
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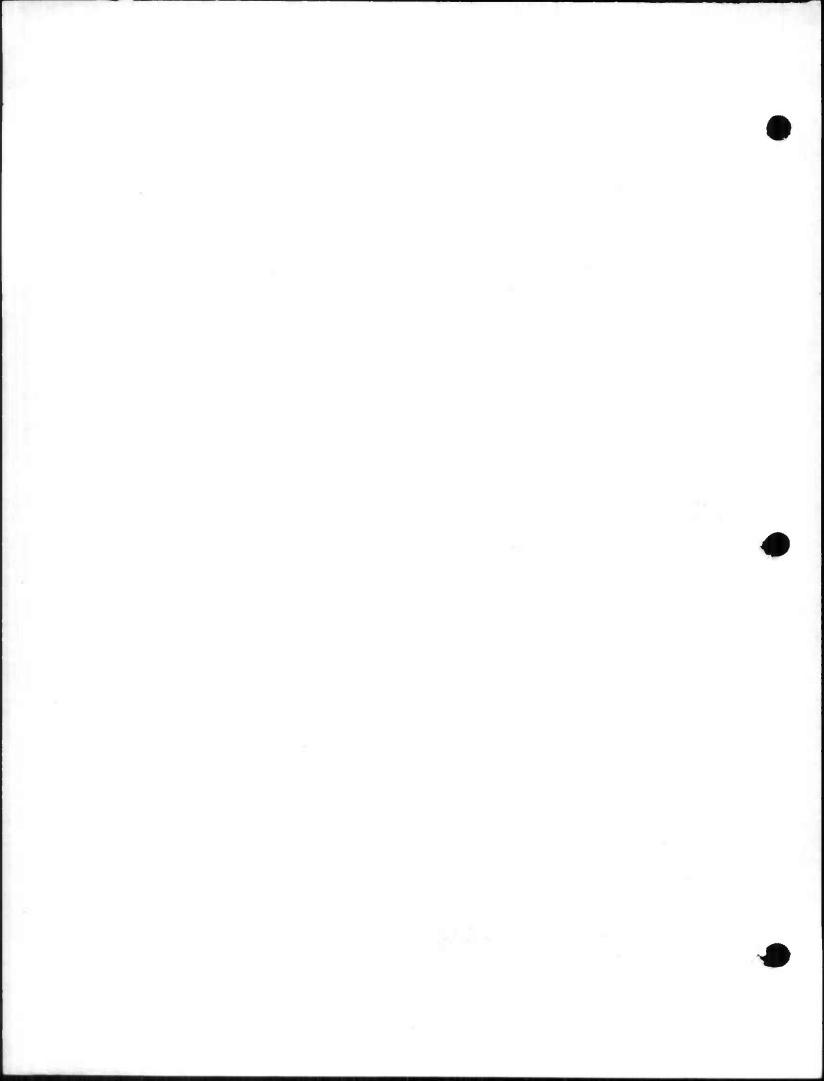
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH YEAR William J. Oct 13 1995 3:30 P.M. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. Sept 30,1914 1X M 2 - F 215-05-2176 81 Maryland detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1541 Colony Road Pasadena Anne Arundel RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY Anne Arundel TYES 2 NO Md Pasadena FUNERAL 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 21122 .S.A. 1541 Colony Road 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 7 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 TES ZENO Specify: Specify: BY 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) DuPont Corp. 8th Engineer 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Sumame) page 5 should be Ħ William . Konieczny Hasse Rose notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 125 Glenlea Drive Glen Burnie Md. 21061 Joan Lloyd pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata must 1 3 Burial 2 Cremetion 3 Removal from Stata funeral director, Cemetery 10/16/95 Baltimore Md 4 Donation 6 Other (Specify) Cedar Hill examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4001 Ritchie Hwy. Leka the Raltimore Md. 21225 medical 5 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abook, or heert fellure. List only one cause on each line. Approximata filled in Interval Between Onset and Death **IMMEDIATE CAUSE (Final** the me to som cremation, disease or condition Com 94 47 pletely reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): and com traumatic MEDICAL CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior tr CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events reaulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO and a any COMPLETION OF CAUSE Signed the 1 YES 2 NO Shows 1 YES 2 NO been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\text{V}}\) UNCERTAIN \(\Boxed{1}\) has be Dept. PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL tem certificate to the State I, or Item OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) HOSPITAL 1 YES 2 70 Inpetient 2 ER/Outpetient 3 DOA 27 MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, this (1 Natural 5 Pending 1 YES 2 NO ВУ After 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 100 6 Could not be determined COMPLETED DIRECTOR: A hours after d Item 28 Is 4 Homicide hours ? Hem. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho MEDICAL EXAMINER: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER mD. D42820 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Chn/Stophen delbon/A 376
31. DATE FILED (Morith. Day Mari 2 Rd. 3708 Mountain OCT 1 7 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



	cian.	-transit permit. Pages 1, 2, 3 should
BALTIMORE, MARYLAND 21215-0020	od within 24 hours after death. Page 6 may be retained by the hospital or attending physician	ompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE,	24 hours after death. Page 6 may be	ompletely filled in by the funeral director, page
194	ed within	ompleteh

DIVISION OF VITAL RECORDS, P.O. BOX 687

TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
e funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
death. Page 6 may be retained by the hospi	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMENT CERTIFICATE		MENTAL HYGIENE REG. NO.		
	t. DECEDENT'S NAME (First, Middle, Last)	4.		0. 527	2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF DEATH
	JOHN WASHIN		CICA OAY yrs. last birthday) IF UNDER	I YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	-	LACE (State or Foreign
	244-18-1476	1 PM 2 0 F 7	YRS. MONTHS	DAYS HOURS MIN.	JAN 22,192	1 14,0	AROLANA
TOR	ST. AGNES RESIDENCE OF DECEDENT	HOSPITAL	- B	4 LTIMORE	96. C	NA	ATH
DIRECTOR	10a. STATE 10b. COUNTY	N/A	10c. CITY, TOWN OF	R LOCATION			10d. INSIDE CITY LIMITE?
	10e. STREET AND NUMBER	11//	1/41	101. ZIP CODE	10g. (YES 2 NO
FUNERAL	3704 WOOD	RIDGE K	D	2122	9	4.51	A
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO 11	WAS DECENDENT OF HISPAI yes, specify Cubari, Mexico YES 2 NO Specifi		- 14. RACE Black,	- American Indian, White, etc.
Э ВҮ	3 Widowed 4 Divorced	1942 -	1946			BL	acx
ETED	15. DECEDENT'S EDUC (Specify only highest grade of	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S USUAL OC (Give kind of work done of life. Do NOT use retired.)	CUPATION uring most of working	16b. KIND OF BUSINESS	INDUSTRY	-0-0
COMPLE	974	Conege (I-4 of 5 T)	MAINTE	VANCE	CATADHC	CAMP	31/165
	TANNES A A HOL	KADA		FOLO	ME (Figs., Microle, Maksan Suman	6)	
TO BE	19g. INFORMANT'S HAME (TyperPrint)	1//	196, MAILING ADDRESS	(Situat and Number or Fore)	Ploute Mumber City or Town, State,	Zip Ciyolej	
F	CARISINE E1 HO	VKADAY	3704	WOODEN	GE KD. B	AFILM	TD. 21229
	1 Buriel 2 □ Cremation 2 □ Remo	ovel from State 200	ARRISON- 17	POSST VA A	10/19/48 Prinns	45 M	115 mp.
	21. BIONATURE OF FUNERAL SERVICE LICE	ENSEE/	22.1	WHE AND ADMINIST OF THE	ABCA FINED	al Abn	DE PA,
	JOHN 1.71	mes	2	70 FREDA	ILTON PASS	Bn17	mp. 2029
		omplications that caused List only one cause on ea	the death. Do not enter ch line.	the mode of dying, suc	h as cardiac or respiratory	errest,	Approximats Interval Between
	iMMEDIATE CAUSE (Final disease or condition	ACDIDAT	ron p	NEVMON	A		FDAYC
	resulting in desth)	DUE TO (OR AS A	CONSEQUENCE OF):				VENNE
NO	Sequentially list conditions, if any, isading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):				/CPIKS
CAT	couse. Enter UNDERLYING CAUSE (Disease or injury	D					
CERTIFICATION	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				
AL CE	PART ii. Other significant conditions	s contributing to death bu	it not resulting in the un	dariying causa given in	Part I. 24s. WAS AN AUTOP	SY 24b.	WERE AUTOPSY FINDINGS
OICA					PERFORMED?		AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
MEDIC					1		1 YES NO
PHYSICIAN:	DID TOBACCO USE CONTR		6. PLACE OF DEATH (Check of		NIX		
rsic	t Tyes 2	HOSPITAL:	tient 3 DOA 4 Nurs	t: sing Home 5 🗆 Residence	6 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY	OCCURED	
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, atc. (Specif	At home, farm, street, factor		281. LOCATION (Street and Num	mber or Rural Ro	oute Number,
ETED	4 Homicide determined	bunung, atc. (Specia	y)		City or Town, State)		
COMPLET					to the cause(a) and manner as		
	200. SIGNATURE AND THE OF SERVICE	-1	and investigation, in my o	29c. LICENSE NU			(Month, Day, Year)
TO BE	20 Barano	- INFDIC	AL RESTO	=09m3	7-53	PCTOB	erc. 13, 95
F	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print)	Α.	20.	005	11821220
	31. DATE FILED (Month Andre	32 PEGIL TRAFFS SIN	GOD, CA	IG , PVC.	BACTIM	nke,	MIJCILLY
	OCIT (1995)	Manual Control					

5% HONES HOPPIAL BAIMMORE 'AW BALTIMORE W.5.17 21229 3704 WOODRIGE R. BLACK 1942 - 1946 CATROLIC CHARITIES MAINTENANCE EVA COOPER JAMES A. HOCKATAY CHRUSING E. HOLKIDAY 3704 WOODRIDGE RD. BATEMOR 21224 CARRISON TOREST V. A 10/19/15 Charles MILLS 17TD,
CAR P. MARCH FUNGERA! ROME PA.
270 FREDAILTON PASS BALTIMO. 2029

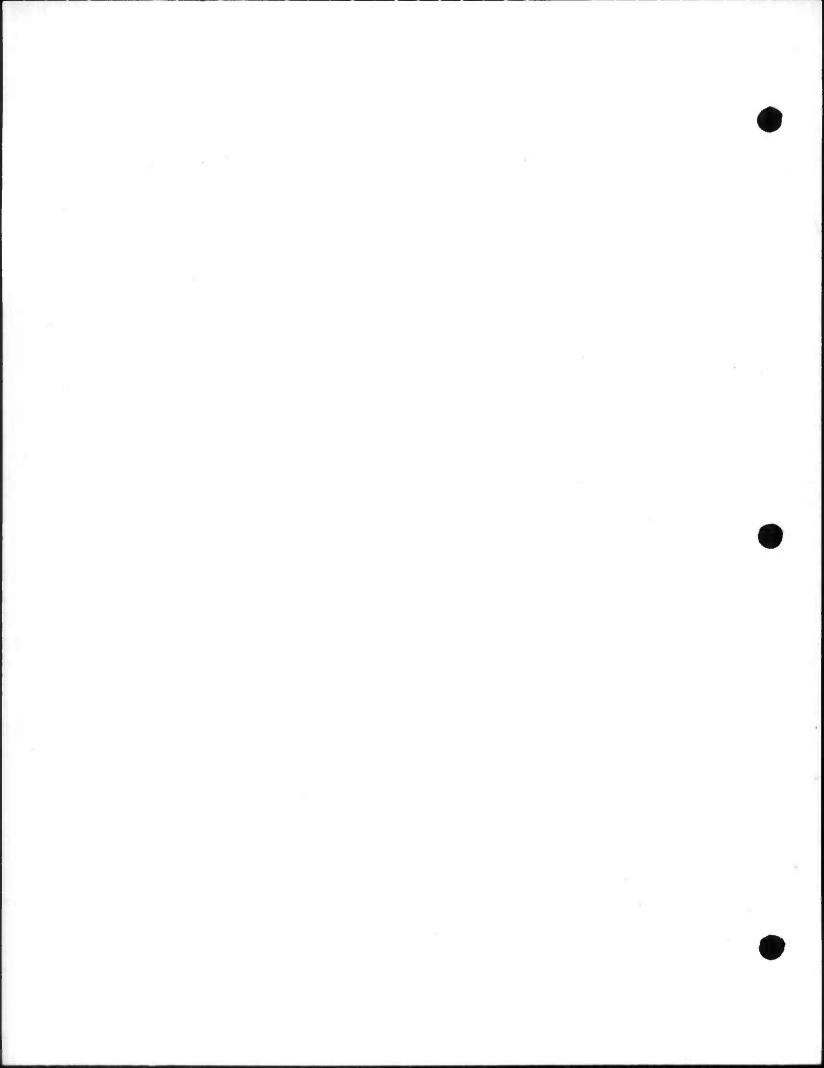
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

NDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1.2.3	, or removal.	medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

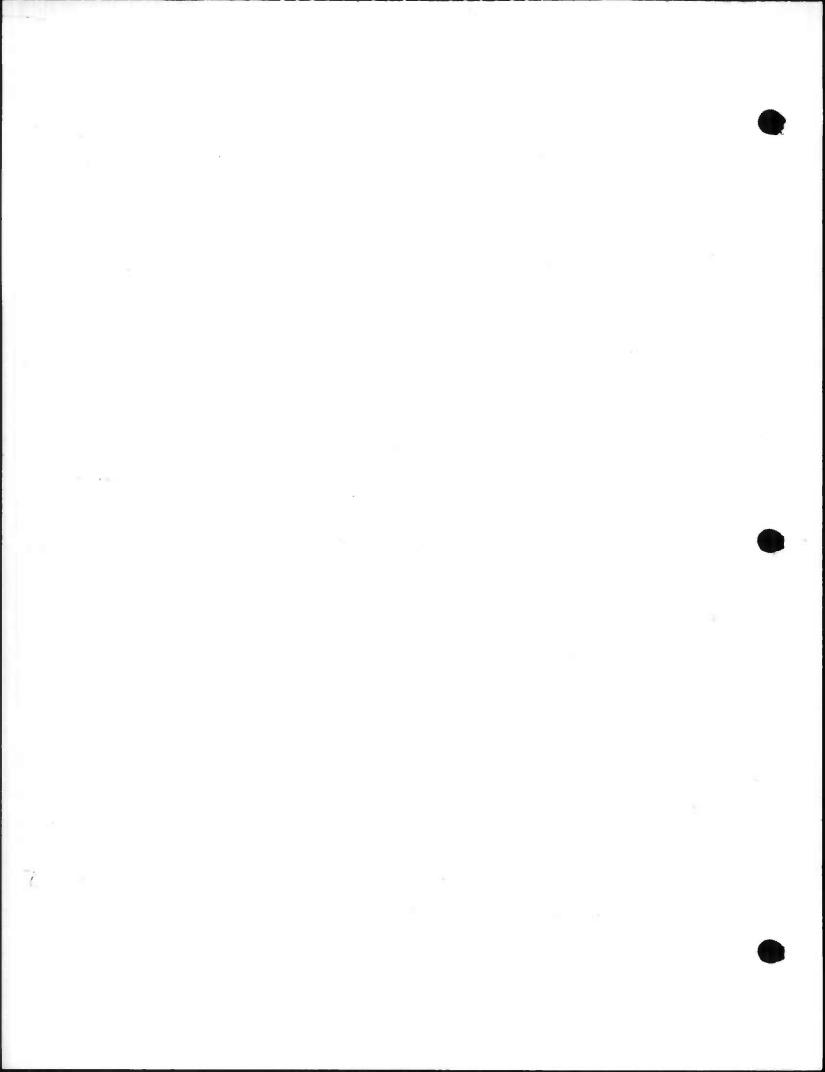
should

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN							
1	1. DECEDENT'S NAME (First, Middle, Last)				BEATT	2. DATE OF DEATH		3. TIME OF DEATH					
	BERNARD	HALL				OCT. 14		6:05 P M					
1 8	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	0.1	BIRTHPLACE (State or Foreign Country)					
	108-14-9432 sa. FACILITY NAME (If not institution, give:	1 x M 2 D F 9	O YRS.			APR. 27	1905 V	IRGINIA					
Œ	MED-ALANTIC NURS				OR LOCATION OF D	EATH	9c. COUNTY						
CTO	RESIDENCE OF DECEDENT	ING HOME		SILVER	SPRING		MONTG	OMERY					
DIRECTOR	D.C.	N/A		INGTON	TION			10d. INSIDE CITY LIMITS?					
	10e. STREET AND NUMBER	N/ A	WASII				· · · · · · · · · · · · · · · · · · ·	1X YES 2 □ NO					
RA	1611 PARK ROAD, N	.W.#407		101	20010		OF WHAT COUNTRY?						
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	D STATES RACE — American Indian.						
BY F	1 Never Married 2 Married 3 N Widowed 4 Divorced	FORCES? 1 YES		It yes, sp	ecify Cuban, Mexice 2 NO Specif	n, Puerto Rican, etc.)		Black, White, atc. Specify:					
	15. DECEDENT'S EDU	ICATION T						LACK					
COMPLETED	(Specify only highest grade	completed)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use r	k done durina ma	ON st of working	16b. KIND OF BU	SINESS/INDUST	RY					
IPLI	7TH	College (1-4 or 5+)	COOK	0.7		BLACKIE	S'S RES	TAURANT					
ON	17. FATHER'S NAME (First, Middle, Lest)					ME (First, Middle, Maiden	Surname)						
BE (BENJAMIN F. HALL				LUCY DU								
2	19a. INFORMANT'S NAME (Type/Print) RUDOLPH N. BACCH	TIC				Route Number, City or Tow WASHINGTON							
	20g, METHOD OF DISPOSITION												
	1 A Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	congression State	PLACE AND DATE OF	DISPOSITION (NA DEMETER		OATE 200 LO	WASHIN						
	21. SIGHATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AP	ID ADDRESS OF FA								
	· miff	Bacar-	276	¥447	BACON FI	NERAL HOME	INC.D	.C. 20010					
\neg	23. PART i. Enter the diseases, or	complications that caused	the death. Do not										
	shock, or heart fellure. iMMEDIATE CAUSE (Final	List only one cause on ea	ich line.					Interval Between Onset and Death					
	disease or condition resulting in deeth)	. PNEUMONIA	A					72 WEEKS					
	DUE TO (OR AS A CONSEQUENCE OF):												
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF)												
AT	If any, leading to immediate cause. Enter UNDERLYING												
Ĕ	CAUSE (Disease or injury that initiated eventa	OUE TO (OR AS A	CONSEQUENCE OF):										
CERTIFICATION	resulting in death) LAST	d											
AL C	PART ii. Other algolificant condition	is contributing to deeth bu	it not resulting in t	the underlying	ceuse given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS					
SC						1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE					
MEDIC							10.11	OF DEATH?					
Ä	DID TOBACCO USE CONT				UNCERTAIL	N 🗆							
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER? Y 1 YES 2 1 NO	HOSPITAL:	6. PLACE OF DEATH	Check only one)									
PHYSICIAN:	27. MANNER OF OEATH	10 Inpetient 2 ER/Outpe	28b, TIME O			6 ☐ Other (Specify) 26d. DESCRIBE HOW II	HIM OCCUPE						
	1 Netural 5 Pending	(Month, Day, Year)	INJUR	Y WO	RK?	200. DESCRIBE NOW II	NJUNT OCCURE						
р ву	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY building, atc. (Specia	At home, farm, atre			261. LOCATION (Street a	and Number or R	ural Route Number,					
COMPLETED	4 Homicide determined	bulleting, att. (Open	77)			City or Town, State)							
PLE	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSI	ICIAN: To the best of my knowle	edge, death occurred a	nt the time, date	and place, and due	to the cause(a) and man	ner as stated,						
Ö	one) 2 MEDICAL EXAMINE	R: On the basis of examination	and/or investigation, i	n my opinion, d	eath occured at the	time, date and piece, an	d due to the cer	use(s) end manner sa stated.					
BE	29b. SIGNATURE AND TOTLE OF CERTIFIER	1/11/1 1/20			29c, LICENSE NUM	MBER	29d. DATE SIG	NED (Month, Day, Year)					
0	A HAME AND A TOTAL OF THE A	ww			D32417		OCT	15 95					
-	RAHUL GILOTKA, 1				MD 2000	2							
				TENTON,	LID 2030	4							
	OCT 1 7 1995	32. REGISTRAR'S SANA	dall		-								



TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MA		DEPAR					MENT	REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Lest) MARGARET L. HERR	rtv							2. DA	ATE OF OEATH	DAY _ YEAR			
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.							TE OF BIRTH	773	a BIDTI	6:15 A M PLACE (State or Foreign	
	213-60-4207	1 🗆 M 2 💢 F	45	YRS.	MONTHS	DAYB	HOURS	MIN.	SE.	onth, Day, Year) PT 26 19	951	LAND		
œ	9a. FACILITY NAME (If not institution, give s		9b. CITY, TOWN OR LOCATION OF DEATH							9c. COUNTY OF DEATH				
DIRECTOR	354 GATEWATER C.	<u>C APT 102</u>			GLE	IN BI	JRNIE				ANNI	E ARU	INDEL	
REC	10e. STATE 10b. COUNT	Y		10c. CIT	, TOWN C	R LOCAT	ION				-	10d, INSIDE CITY LIMITS?		
		ARUNDEL	GLEN BURNIE									1 TYES 2 NO		
FUNERAL	10e. STREET AND NUMBER				177	ZIP CODE				10g. CIT	HAT COUNTRY?			
)NE	354 GATEWATER CT	VER IN U.S. AR	MED	142		060	LICONAN	10.00	GIN? (Specify Yes					
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	YES 2 X	NO		f yes, sp	2 TVNO	, Maxicar	1, Puer	to Rican, etc.)	or no—	Speci WHIT	— American Indian, , White, etc. V: E		
	15. DECEOENT'S EDU (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N et of weeking			16b. KIND OF BUS	INESS/INI			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT us	e retired.)		n or worning							
ME	12 17. FATHER'S NAME (First, Middle, Lest)			HOUSEWIFE 18. MOTHER'S NAME (Fin							1 HOI	Æ		
	JOHN M. TWELE									RIMBLE	Surname)			
) BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AOORESS	(Street a					n, State, Zip Code)			
5	THOMAS HERRITY 354 GATEWATER CT GLEN BURNIE MD 21060													
	20a. METHOD OF DISPOSITION 1													
	21. SIGNATURE OF FUNERAL SERVICE-LIC	ENSEE /	1		22.	NAME AN	D ADDRESS	S OF FAC	HLITY					
	· Lild X	It-pl	4							FUNERAL GLEN BU			21061	
N	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onest and Death DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.													
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 YES DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF OEAT	H (Check	only one)					-			
PHYSICIAN:	1 TYES 2 XNO	HOSPITAL:		□ DOA	OTHER		5 700	Idenca (5 🗆 O	ther (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJ (Month, Day, 1)		26b. TIMI INJI	JRY J	28c. tNJI WO	RIC?	. [28d. [DESCRIBE HOW IN	JURY OC	CURED		
B	2 Accident Investigation	26a. PLACE OF IN	JURY — At ho	me, tarm, s	treet, facto		ES 2 🗌	NO	261 1	OCATION (Street or	nri Akumbai	or Pural P	nute Mumber	
TED	3 Suicide 6 Could not be 4 Homtcide determined	building, etc.	(Specify)	URY — At home, term, street, factory, office Specify) 28f. LOCATE City or 1							CATION (Street and Number or Rural Route Number, r or Town, State)			
COMPLETE		CIAN: To the best of my											and manner as stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	m	01	NCOL	0913	1+1	29c. LICEN	SE NUM	BER	_	29d. DAT	E SIGNED	(Month, Day, Year)	
6	/MOMIN/ OD	Lallon	mo		<i>-</i>		() C	779	13	0	1	£4.	17, 1793	
	MARVIN J. FELDMAN	,MD MERCY	MEDI CA			301	ST.	PAU	L P	LACE SU	ITE	407		
	"OCTI" "7"1995" Jul	REGISTRARIA	SIGNATURE								X			



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Fage 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF N		RTIFI					ILITIAL	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	D/		YEAR	3. TIME OF DEATH	
	Morris L. Hai	s. SEX	B ACE //n use too	. 51-15-15-15						LOBE	R 10	1795	06:70 WM	
		E. BINTH										8. BIRTHPI Country)	LACE (State or Foreign	
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE												ATH	
5	Union Memorial Hospital Baltimore City													
DIRECTOR	10e. STATE 10b. COUNTY Maryland			10c. CITY Bal	town o	n LOCAT	ION				IOd. INSIDE CITY LIMITS? K YES 2 NO			
AL	10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF										ZEN OF WI	IAT COUNTRY?		
EB	3034 Guilford Av	enue					212	218			(I.S.A		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 X Divorced	12. WAS DECEDEN	YES 2 N		1	f yee, sp		n, Mexicar	n, Puerto Ri	(Specify Yes	or No-	14. RACE - Black, Specify	American Indian, White, etc. White	
ED E												***************************************		
COMPLETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY													
E COM	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAI	ME (First, M	iddle, Maiden	Sumame)			
TO B	19e. INFORMANT'S NAME (Type/Print)		190	b. MAILING	ADORESS	(Street e	nd Number	or Rural R	loute Numb	er, City or Tow	n, State, Zip	Code)		
	20a. METHOD OF DISPOSITION 1		20b. PLACE is cemetery, cre			ITION (Na	me of		OATE	20c. LO	CATION —	City or Tow	n, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC		ld wade,	Dir.	22.	NAME AN	ID AOORES	S OF FAC	CILITY	1		- 0.16		
	Joseph B.	Van.	fent	/	S								more Street 01-1559	
1	23. PART I. Enter the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, Approximate Interval Between Onset and Death													
	disease or condition a. BRAIN DEATH NIETHOR AS A CONSEQUENCE OF												1 DAY	
z	ENCEPHALOPATHY 4 DAYS													
5	Sequentially list conditions, If any, leeding to immediate ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF):												4 DAYS	
S	CAUSE (Disease or injury		PERZTEN!			Mer	ZGEN	icy					70445	
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	QUENCE OF	7):									
CE	d													
7	PART ii. Other algnificent condition	contributing to	deeth but not i	esuiting i	n the un	iderlyin	ceuse g	lven in	Part i.	24a, WAS AN PERFOR			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
73									- 1	1 YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?	
DIC	OF DEATH?												TES 2 NO	
MEDIC	P.D. TODA 4000 1107 001 1111	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
AN: MEDIC		SIBUIE TO CA	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
ICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER	R:								
IYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nur	sing Hom		eldence	8 🗆 Other	,-,-,,				
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA 28b. TIMI	OTHER 4 Num E OF URY	28c. INJ WO	URY AT			(Specify)	NJURY OC	CUREO		
ВУ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 (V) YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation	HOSPITAL: 1 Inpatient 2 (28a, DATE OF (Month, D	ER/Outpatient 3 INJURY ay, Year)	DOA 28b. TIMI	OTHER 4 Num E OF URY	28c. INJ WO	URY AT PK? YES 2		28d. DES	CRIBE HOW I				
ВУ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 (1) YES 2 \(\text{\tilitt{\tex{\tex	1 Inpatient 2 28a. DATE OF (Month, D	ER/Outpatient 3	DOA 28b. TIMI	OTHER 4 Num E OF URY	28c. INJ WO	URY AT PK? YES 2		28d. DES	,-,-,,	and Number		tule Number,	
ВУ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF OEATH 1 Neturel 5 Pending Investigation 3 Suicide 8 Could not be detarmined	1 Inpatient 2 C 28a. DATE OF (Month, D	ER/Outpatient 3 INJURY ay, Year) F INJURY — At ho atc. (Specify)	28b. TiM INJ	OTHER 4 Num E OF URY M	28c. INJ WC 1	URY AT IRK? YES 2] NO	28d. DESC 28t. LOCA City o	TION (Street or Town, State)	and Number	r or Rural Ro	rute Number,	
PLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMÍNER? 1 1 YES 2 NO 27. MANNER OF OEATH 1 Neturel 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	28a. DATE OF (Month, D	ER/Outpatient 3 INJURY ay, Year) F INJURY — At ho atc. (Specify) my knowledga, de	28b. TiMi INJ	OTHER 4 Num E OF URY M street, fact	28c. INJ WC 1	URY AT PK? YES 2 end pleca,	NO and due	28t. LOCA City of	CRIBE HOW I	and Number	r or Rural Ro		
BY	25. WAS CASE REFERRED TO MEDICAL EXAMÍNER? 1 1 YES 2 NO 27. MANNER OF OEATH 1 Neturel 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	28a. DATE OF (Month, Dullding, CIAN: To the best of experience of experience)	ER/Outpatient 3 INJURY ay, Year) F INJURY — At ho atc. (Specify) my knowledga, de	28b. TiMi INJ	OTHER 4 Num E OF URY M street, fact	28c. INJ WC 1	URY AT PK? YES 2 end pleca,	NO No	28t. LOCA City of to the caus	CRIBE HOW I	and Number	r or Rural Ro Red. ne cause(s)	end manner es stated. Month, Dey, Vear)	

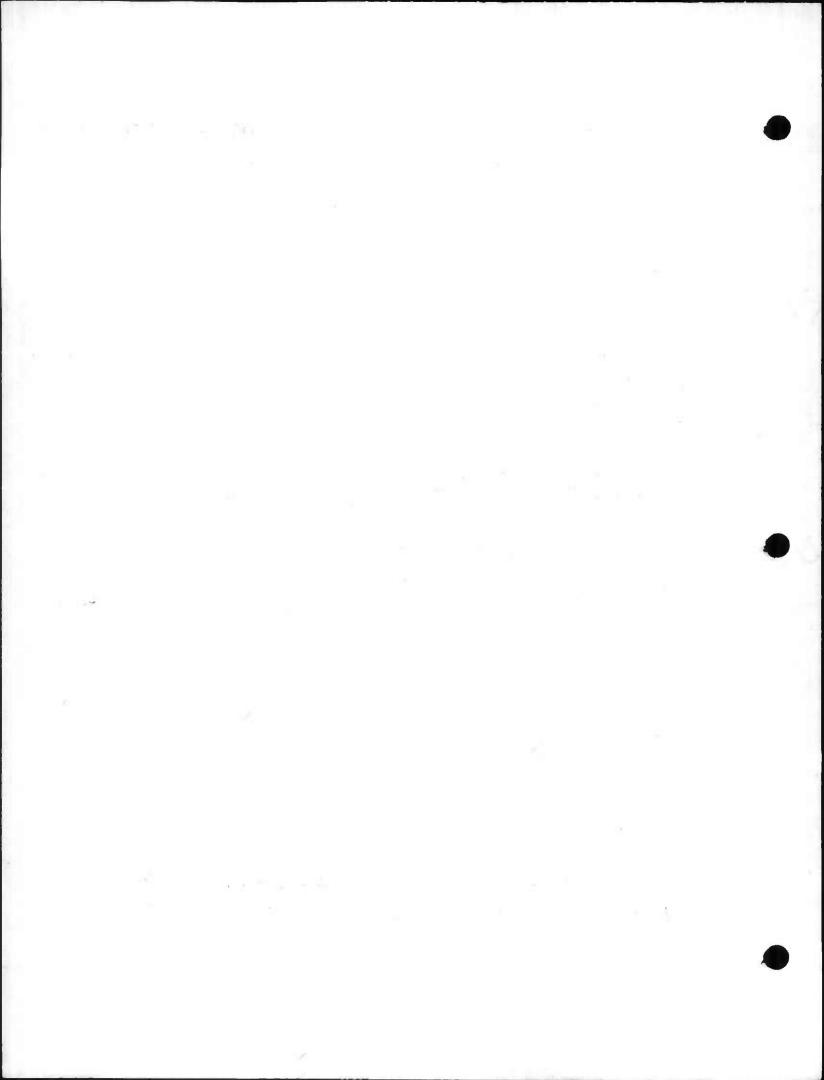
AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

UNION MEMORIAL HOSPITAL

SCHEGISTRATISHINATURE

Jaha dandin Randall

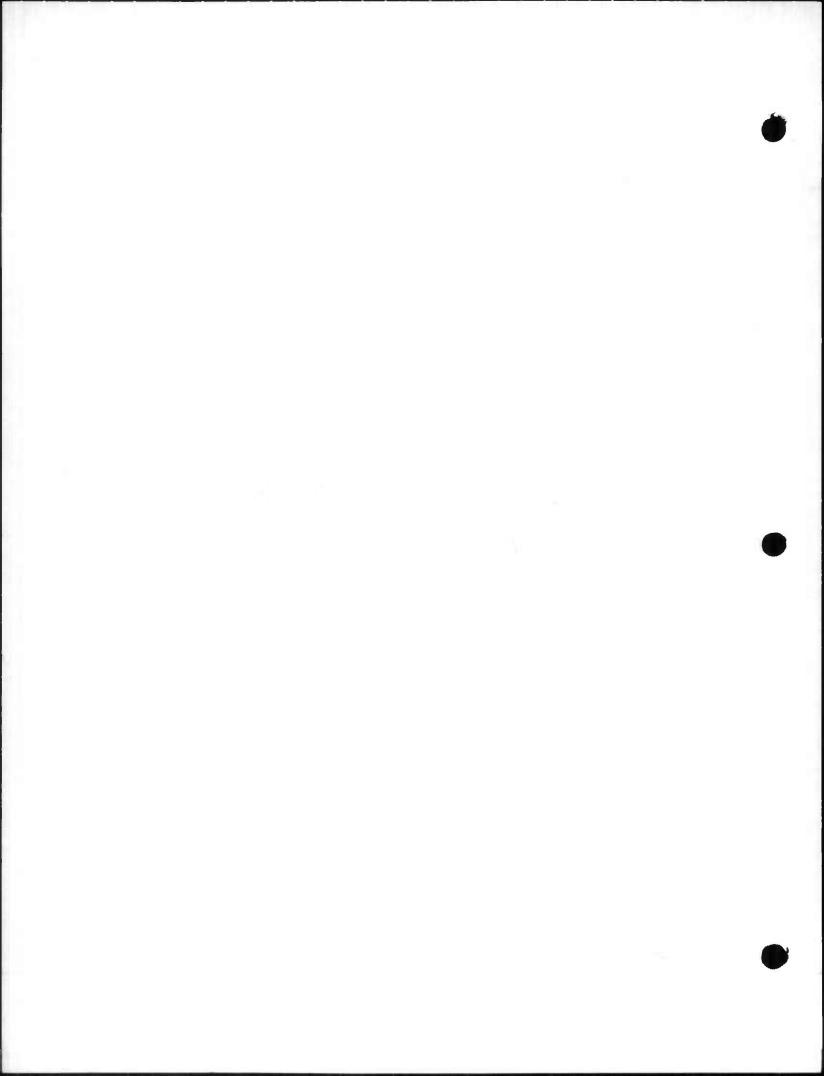
RICHARD LAMSON

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		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I			HYGIENE REG. NO.		
	8	1. DECEDENT'S NAME (First, Middle, Last) Carl	Rogge	Hil	genberg		2. DATE OF MONTH	DEATH DAY er 12, 19	year 95 7:50 a	
Pa	8	4. SOCIAL SECURITY NUMBER 056-09-4681	1 🛣 M 2 🗆 F	(In yrs. leat birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	BIRTH by. Year) 25,1908	BIRTHPLACE (State or Foreign Country) MARYLAND	
, 2, 3 should	стоя	9a. FACILITY NAME (If not institution, give a BROADMEAD RESIDENCE OF DECEDENT	treet and number)			OR LOCATION OF D		72/10/20	ALTIMORE	
Pages 1,	DIREC	10a. STATE 10b. COUNT	LTIMORE	10c. Cr	TY, TOWN OR LOCA	CKEYSV	TTTD		10d. INSIDE CITY LIMITS?	
permit.	RAL D	10e. STREET AND NUMBER	IN THORE			H. ZIP CODE	TLLE	10g. CITI	1 TYES TONO	
#	FUNER	13801 YORK	ROAD 12. WAS DECEDENT EVER II	N U.S. ARMED	12 WAS DE	2103		U.S.A. fee or No. 14. RACE — American Indian,		
215-0020 attending physician. use as the burial-trans	BY	1 Never Married XX Married 3 Widowed 4 Divorced	FORCES? 1 TYES	5XX10	If yes, ap	pecify Cuban, Mexic S X X NO Speci	an, Puerto Rica	in, etc.)	Black, White, etc. Specify: WHITE	
- a.	ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)		S USUAL OCCUPATE work done during me use retired.)			ND OF BUSINESS/IND	USTRY	
ND hospita ached	COMPL	3		BUSIN	ESS EXE				EY GLASS CO.	
by the	ш	17. FATHER'S NAME (First, Middle, Last) CARL GEORGE	HILGENBER	e G			AME (First, Midd ELICA	ROGGE		
MA retain 5 sho	TO B	190. IMFORMANT'S NAME (Type/Print) JOHN C.HILGENE	BERG (SON)					City or Town, State, Zip		
6 may ctor, pa		20s METHOD OF DISPOSITION 11 Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State CON	netery, crematory or	OF DISPOSITION (No		DATE	20c. LOCATION —		
ALTIM death. Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	KUID R	22. NAME A	ND ADDRESS OF FA	ACILITY		VILLE, MD. 2120	
	Щ	· Rod Bur			4905	YORK		BALTIMOF	RE, MD., 21212	
Par in		23. PART I. Enter the diseases, pr shock, or hear failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. PARK	INSO	NS	DISE			Approximate interval Between Onset and Death	
certificate be executing physician and ingression of the contraction o	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE C	OF):					
e deat he atte Mentai	뜅	PART II. Other significant condition	e contributing to death b	ut not reaulting	in the underlyin	g cause given in	Part i. 24	a. WAS AN AUTOPSY.	24b. WERE AUTOPSY FINDINGS	
requires the signed of Health	: MEDICAL	DEMEN SHINGL	TJA ES				PERFORMED?	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN: The law certificate has be the State Dept.	SICIAN:	25. WAS CASE REFERRED PO MEDICAL EXAMINER?	HOSPITAL:		26. PI	LACE OF DEATH (C)	heck only one)		INM	
SICIAN: certific the Si	PHYS	1 VES 2 DAO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outs 28a. DATE OF INJURY	28b, Till	4 Nursing Hon	ne 5 🗆 Residence		pecify) IBE HOW INJURY OCC	CURFO	
DING PHYS After this death with	ВУ Р	1 Distural 5 Pending 2 Accident Investigation	(Month, Day, Year)		JURY WO	YES 2 NO				
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory, offic	De .		ON (Street and Number own, State)	or Rural Route Number,	
로 글 전 =	COMPL		CIAN: To the best of my know						ed, e cause(a) and manner se stated,	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	BE	296 AIGNATURE AND TITLE OF CERTIFIE	croll 7	m		D383	MBER 392	29d. DATE	O 112/95	
13	10	30. NAME AND ADDRESS OF PERSON WHE	O COMPLETED CAUSE OF DE	TH (ITEM 27) (Type	3801 \	YORK :	RD	COCKEV	SVILLE, MD	
′ <		31. DATE FILED (Morith, Day, 16er) OCT 1 7 1995	32. REGISTRAR'S SIGN			¥	1	1	/ -	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the forest. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

Nicholas

31. DATE FILED (Month, Day, Year)

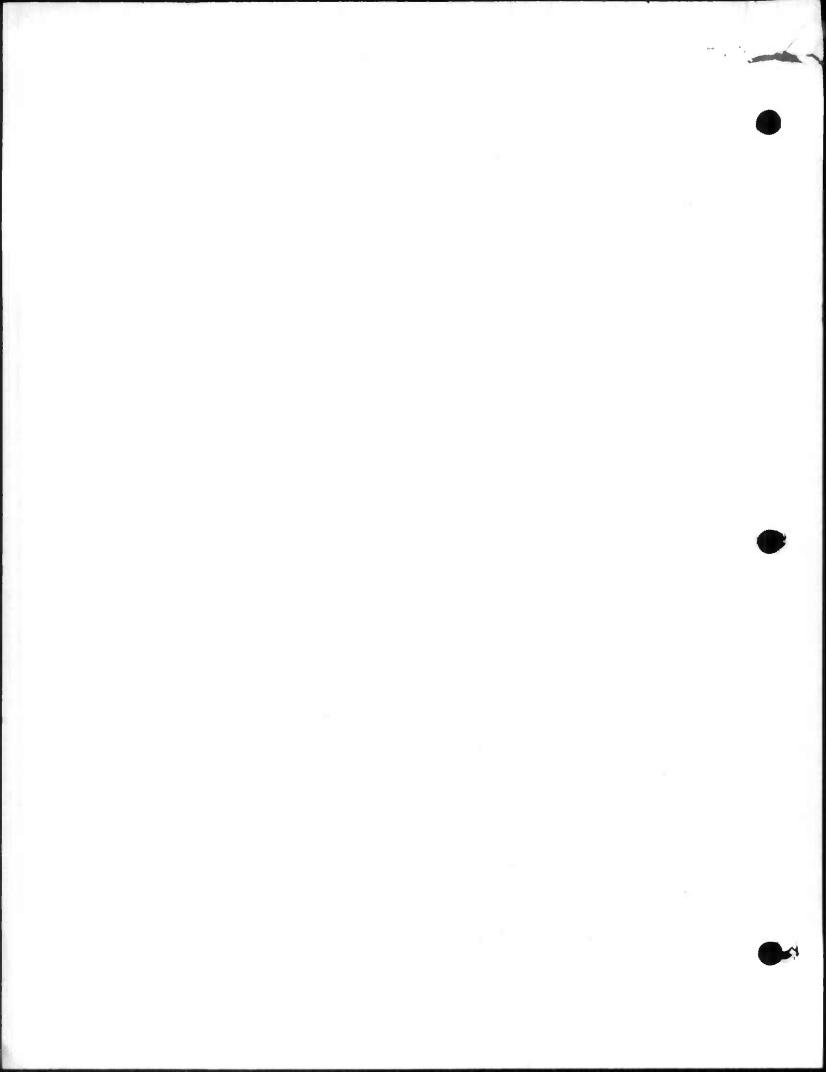
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M.D.

Argento,

	Item2 10-1/-	-95 FilmG728	W.H.Pe	r F/H				CIL	5 31136			
	FOR STATE REGISTRAR	STATE OF MARYLAN				D MEN		E				
	1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	FICATE O	DEATH	100	REG. NO.		I a de la constantina			
	Glocia	1/	1	targe		Öc	DATE OF DEATH	14	YEAR 3. TIME OF DEATH			
		5. SEX 8. AGE (In v	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	7.0	ATE OF BIRTH	7	BIRTNPLACE (State or Foreign			
		1 □ M 2 X F 71	YRS.	MONTHS DAYS	7	N. (A	Worth, Day, Year)		Country)			
	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOW	OR LOCATION OF		or. 28,		lashington, D.C.			
H	Howard County Gene			Columb		- William		Howa				
5	RESIDENCE OF DECEDENT	Har Hoopton						110				
DIRECTOR	MD HOWAY	n.a.		ry, town on loc Columbia				10d. INSIDE CITY LIMITS?				
		<u>.a</u>							1 TYES 2 NO			
BY FUNERAL	100. STREET AND NUMBER		,	Of. ZIP CODE				N OF WHAT COUNTRY?				
2	5764 Stevens Fore				21045				JSA			
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc.												
3 ☑ Widowed 4 □ Divorced IF YES, OIVE WAR OR DATES 1 □ YES 2 ☑ NO Specify: Specify: White												
E												
Ē	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)											
COMPLETED		None E	xecutiv	ve Secre	etary		Federal	Reser	ve Bank			
00	17. FATNER'S NAME (First, Middle, Last)						irst, Middle, Maiden :	Surname)				
BE	S. Kinsley Upperma	an					perman					
5	19a. INFORMANT'S NAME (Type/Print)	Sauchton in 1	19b. MAILING	ADDRESS (Street	and Number or Ru	rel Route A	Number, City or Town	n, State, Zip Co	21042			
	Maryellen Harper (D						ITU, ELL.	ICOLL	CITY, MD			
	1 ☐ Buriel 2 N Cremation 3 ☐ Remove	val from State cemeter	ry, crematory or o	OF DISPOSITION (I	[]				y or Town, Stata			
8	4 Donation 5 Other (Specify)	Meti	ro Crem	natory			995 Cato	onsvii	le, MD			
	111	1.14	1	Leroy		ıssel	l C Witz		neral Home			
	P. (10.	Worle	1	5555	Twin Kn	nolls	Rd. Co.	lumbia	, MD 21045			
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	emplications that caused the lat only one cause on each	e death. Do r	not enter the m	ode of dying, s	such aa c	cardiac or reapir	ratory arres	t, Approximata interval Between			
	IMMEDIATE CAUSE (Finel			4	. 0	. ^			Onset and Death			
	disease or condition resulting in desth) a.	me		2415								
ON	Sequentially list conditions,	7										
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	- 2	-0	In Da	-8	1		1 4			
IFIC	CAUSE (Disease or Injury that initisted events	DUE TO (OR AS A CO	MSEQUENCE OF	F):	MITA	Jei	100					
F	resulting in deeth) LAST											
O	DATE II Other elevitions conditions											
MEDICAL	PART II. Other eignificent conditions	contributing to death but r	not resulting a	in the underlyi	ng ceuse given	in Part I	I. 24s. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
ğ	On Andrew	Cock, Co					1 TYES 2	NO	COMPLETION OF CAUSE OF DEATH?			
Σ	DID TODASCO HIST SONTON			1					1 TES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONTRII 25. WAS CASE REFERRED TO MEDICAL			ES NO	UNCERTA	AIN 🗆						
SC	EXAMINER?	HOSPITAL:		TH (Check only one OTHER:								
HYS	1 VES 2 NO 1	1 Inpetient 2 ER/Outpetie	ent 3 🗆 DOA		me 5 🗆 Rasideno							
	1 Natural 5 Pending	(Month, Day, Year)	INJ	JURY W	ORK?	200.	DESCRIBE HOW IN	JURY OCCUR	IED			
) BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY /	At home, farm, i			28f, [LOCATION (Street as	nd Number or	Pural Route Number			
TED	4 Homicide determined	building, etc. (Specify)					City or Town, State)	Trusta -	HUNE HUNE HUNDEN			
ZE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledg	ne death occum	and at the time de	and sleep and	to the	- Louis					
<u> </u>	(Check only The CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and dus to the cause(s) and manner as stated.											
\geq	one) 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
COMPLET	2 MEDICAL EXAMINER:	On the besis of axamination ar	naror investigant	an, in my opinion,								
TO BE COM	2 MEDICAL EXAMINER:	Attende		on, in my opinion,	29c. LICENSE N				IGNED (Month, Day, Weer)			

14201 Laurel Park Drive, Laurel, MD 20707



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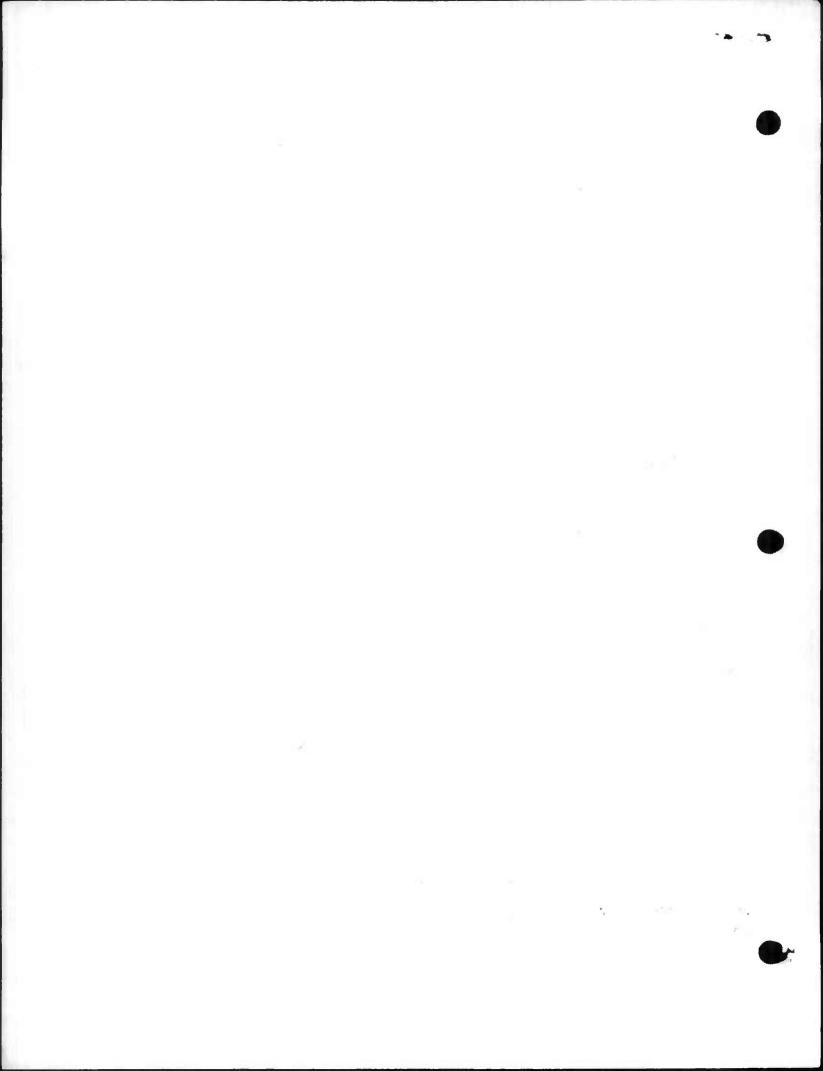
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	CATE (OF DEATH		REG. NO).			
	1. DECEDENT'S NAME (First,	Middle, Last)							ATE OF DEATH			3. TIME OF DEATH	
	THOMAS	BRA	DFORD	HARD	T				TOBER 1	AY 3. 19	YEAR	7:00 AM	
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER 1 YE		HRS. 7. D/	TE OF BIRTH	-,	8. BIRTH	HPLACE (State or Foreign	
	466-20-9178		1 🔀 M 2 🗆 F	71	YRS.	MONTHS DA	VS HOURS N		B. 7, 1	924	TEX		
	9a. FACILITY NAME (If not ins	titution, give a	street and number)	-1-1		9b. CITY, TO	WN OR LOCATION		<i>D</i> • / ,		JNTY OF D		
H	212 DITTY C	OURT				GLE	N BURNIE					RUNDEL	
DIMECTOR	RESIDENCE OF DEC	EDENT											
-	10a. STATE	10b. COUNT	Υ	OCATION					10d. INSIDE CITY				
5	MD	ANN	E ARUNDEL		GLE	EN BUR	NIE					LIMITS?	
LONERAL	10e. STREET AND NUMBER						101. ZIP CODE			WHAT COUNTRY?			
	212 DITTY C	OURT					21060)		II	.S.A.		
5	11. MARITAL STATUS		12. WAS DECEDENT	EVER IN U.S.	ARMED	13, WAS	DECENDENT OF H	IISPANIC OR	GIN? (Specify Ye			E — American Indian.	
	1 Never Married 2 🖔		FORCES? 1 F	YES 2	□NO	If yo	s, specify Cuban, N YES 2 NO S	fexican, Pue	rio Rican, etc.)		Biaci	k, White, etc.	
0	3 Widowed 4 Divor	ced			WWII	1	TES ZAL NO	эрвину.			Spec	WHITE	
3	16. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Glaw kind of work done during most of working											MULTE	
<u>.</u>	Elementary/Secondary (0-	-	College (1-4 or 5+)	_	ille. Do NOT us	rork done durin e retired.)	g most of working						
<u> </u>	12		0		SELE	EMPL	OYED		VENDIN	G MA	CHINI	ES	
LWO	17. FATHER'S NAME (First, Mic	ddle, Last)					16. MOTHER	'S NAME (Fir	st, Middle, Maiden	Sumame)			
	FRED EUGENE	наврт					VELM						
10	19a. INFORMANT'S NAME (Ty				19b. MAILING	ADDRESS (St				in Code)			
2	EDITH M. HAR						the Number, City or Town, State, Zip Code) BURNIE, MD 21060						
	20a. METHOD OF DISPOSITION												
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cameter); or other place) DATE 20c. LOCATION — City or Town, Stet 4 Donation 6 Other (Specify) CLEN HAVEN MEMORIAL PARK 10/16/95 GLEN BURNIE												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											RNIE, MD	
	80	u	9/	/			GLETON F		L HOME				
	n. x	learn	e- Hank	Ein-						N BU	RNIE	, MD 21061	
	23. PART I. Enter the disabook, or he IMMEDIATE CAUSE (Find disease or condition resulting in death)	ert fellure.	List only one caus	e on each I	ine.		edder			iratory ar	reat,	Approximate Interval Batwee Onset and Dear	
	DUE TO (OR AS A CONSEQUENCE OF):												
HILLIAMION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING												
	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
	resulting in death) LAST												
2	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS												
	PARI II. Other algnificar	t condition	18 contributing to d	ot reaulting i	n the under	lying ceuse give	n in Part I	24a. WAS AN PERFOR	MED?	24b	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
									1 1 163 4	NO		OF DEATH?	
	DID TOBACCO US	E CONT	RIBUTE TO CALL	ISE OF DI	FATH YE	SINO	IINCED	TAIN [7				1 WES 2 NO	
	25. WAS CASE REFERRED TO		INDUIT TO CAU		LACE OF DEAT			IMIN L					
	EXAMINER?		HOSPITAL:			OTHER:	./						
	27. MANNER OF DEATH		1 - Impetiant 2 - I		3 DOA 28b. TIME	4 Nursing			ther (Specify)				
- 4	N -1'	ending	(Month, Day,		INJU	JRY	INJURY AT WORK?		DESCRIBE HOW I	NJURY OC	CURED		
	2 Accident in	rvestigation	20. 21.107.07	thi married			YES 2 NO	_					
		could not be	26s. PLACE OF building, et	injury — At ic. (Specify)	home, farm, si	ireet, factory,	offica	207. L	OCATION (Street in City or Town, State)	and Number	r or Rural F	Route Number,	
	— mines												
	(Check only	FYING PHYSI	CIAN: To the beat of m	y knowledge,	death occurre	d at the time,	date and place, and	d due to the	cause(a) and mar	nner as stat	ted,		
) and manner as stated.	
	296. SIGNATURE AND TITLE						29c. LICENSE					(Month, Day, Year)	
	Ch. C	4	(211. M	D			DIA	1410		290. DAI	10/	13 / C.	
	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUSE	OF DEATH #	TEM 27) (Time	Print)	J. T.				.9/	10/42	
	Ann Cm	110.	mn c	300	Roal.	11-	DA C	1 3	DO A	0.00	11.	mr v	
	31. DATE FILED (Month, Day, Y	Mar)	32. REGISTRAR	S SIGNATURE	عاديا (216	Na, Jur	TE O	00,111	riepo	رساد	111 2110	
	OCT 1 7100	5	he Skudson			,	•						
	AA Y 132	J /2	my arman	W. Alla A									
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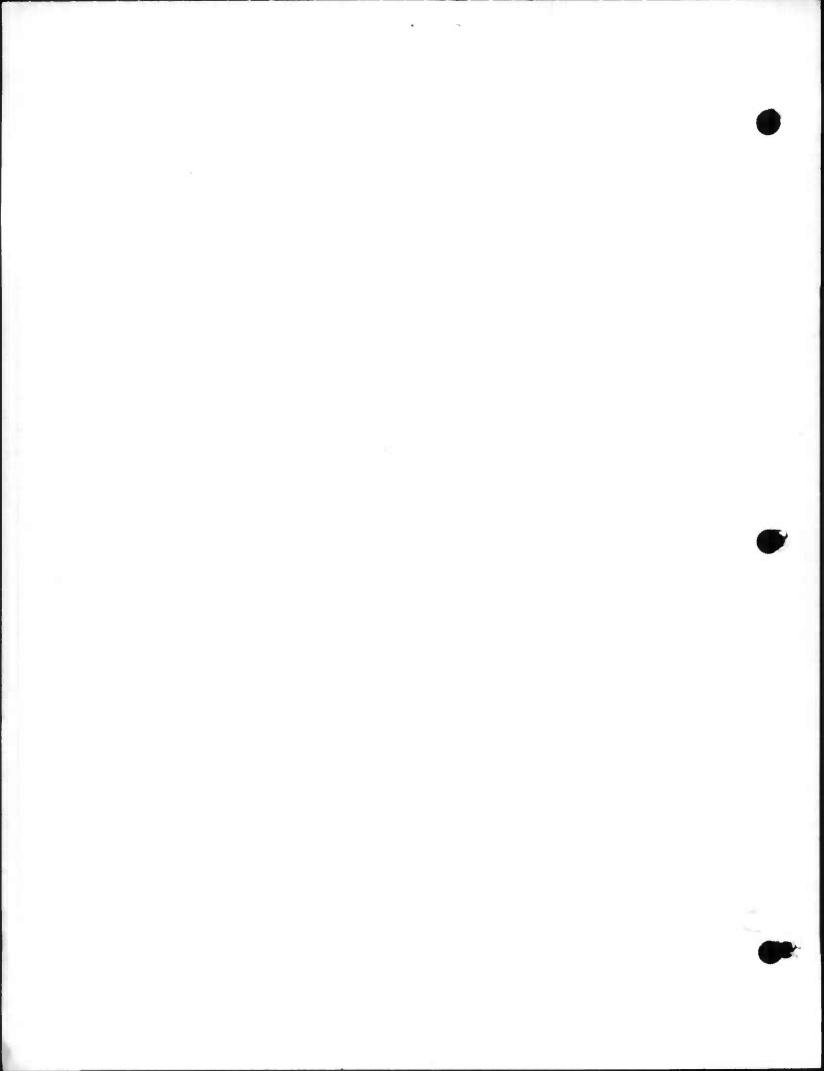
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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	NEGISTRAN		-	_ , , , , , ,	ICAIL	- 01	DICA			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM FRANCIS	JONES							2. DATE OF MONTH OCTOB	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t hirthriau)	IF UNDER	1 VEAD	IF UNDER	24 1000	7. DATE OF		±/ 13		10:45P M
	213-09-8947	1 🔀 M 2 🗆 F	78	YRS.	MONTHS				(Month, Day, Year) January 4,1917 Mary				1)
	9e. FACILITY NAME (If not institution, give str		9b. CITY,	9b. CITY, TOWN OR LOCATION OF DEATH 9c. CC						NTY OF DE			
6	Perry Point Veter	Perry Point						Cecil					
띮	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY	Y, TOWN OR LOCATION											
DIRECTOR	Maryland	N/A	Baltimore						LIMITS			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
A	10e, STREET AND NUMBER			101. ZIP CODE							HAT COUNTRY?		
FUNERAL	5070 Orville Aver	nue	21205							Α.			
5	11. MARITAL STATUS	12. WAS DECEDEN			13, V	MAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (S	pecify Yes	- American Indian.		
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W	∭YE\$2□N MRORDATES VII		12.							Specify	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of		(Gi	ve kind of v	USUAL OC	CUPATIO	ON st of working	na	16b. Kili	ND OF BUS	INESS/INC	DUSTRY	WIIICE
9	Elementary/Secondary (0-12)	College (1-4 or 5 +		Do NOT us	retired.)								
ğΙ	Unknown 17. FATHER'S NAME (First, Middle, Lest)			Unk	nown					Unkn			
8									AE (First, Midd		Surname)		
H	William F. Jones 190. INFORMANT'S NAME (Type/Print)								ene Mu				
2			1						loute Number,				
	Elizabeth Berger (oad,					d 21206		
	20g, METHOD OF DISPOSITION 1 [X] Buriel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	melory or o	of DISPOSI	rn, State									
	4 Donation 5 Dother (Specify) New Cathedral Cemetery 10/18/95 Baltimore, Ma 21. SIGNATURE OF FUNERAL SERVICE LICENSEE												aryland
	Probert A Do	dans.		5	Schi	munel	k Fur	neral	Home		W -	21213 ryland	
	23. PART I. Enter the diseases, or co	omplications that	coused the de	ath. Do r	not enter	the mo	de of dy	ing, auch	an cardiac	or respin	ratory arr	eat.	Approximata
	ahock, or heert failure. L	lat only one cau	se on eech line.										interval Between Onset and Death
	disease or condition condi												
ĺ	DUE TO (OR AS A CONSEQUENCE OF):												
Z	Sequentially list conditions. Pneumonia 2 Weeks												
E	If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
3	CAUSE (Disease or Injury												
EDICAL CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
点	d												
اپر	PART II. Other algnificent conditions	contributing to	death but not re	esuiting l	n the un	derlying	cause g	given in F	Part I. 24	. WAS AN			WERE AUTOPSY FINOINGS
S										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME									_ ''		23 110		OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S D N	10 🗆	UNC	ERTAIN	1 20				
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ACCEPTAGE 26. PLACE OF DEATH (Check only one)												
is	and the same of th	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Re	eldence (B ☐ Other (St	pecify)			
된	27. MANNER OF OEATH	28e. DATE OF (Month, De		28b. TIM	_	28c. INJI	JRY AT	$\neg \neg$	26d. DESCRI		JURY OCC	CURED	
BY	1 Netural 5 Pending 2 Accident Investigation				М	1 🗌 Y		NO					
	3 Suicide 8 Could not be determined	26e. PLACE Of building,	F INJURY — At horetc. (Specify)	ne, farm, s	treet, fecto	ory, office			28f. LOCATIO City or To	N (Street eawn, Stete)	nd Number	or Rural Ro	ute Number,
9	29e. CERTIFIER	AB. To the A									Po-100		
COMPLETED	(Check only one) 1												end menner ee stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIER	Low	14.00	K 11	\bigcap	T	29c, LICE	NSE NUM	BER	I	29d. DATE	E SIGNEO (Month, Day, Year)
0	1 while	1001	100	NA			D3	8950			10	7-1	4-95
	30. NAME AND ADDRESS OF PERSON WHO Manuel Ramos, M.I		e of Death (ITEN C Perry			יזיייב	Pos	nt '	מא פוע	902			
		32. REGISTRA	R'S NATURE	- OIII	C/ PE	ELLY	FOI	IIL, I	בא עויי	.502			
	31 OCT 1007 7995 Ju	in directed	readed										



FOR

FilmG, 729, item #20b, 11/07/95.cyw, per f.h.

		1 - STATE REGISTRAR		DIAIE UP N	MANTLAI	CERTIF	ICATE	OF H	DEAT	тип п ГН	MENIA	REG. NO.	E		
		1. DECEDENT'S NAME (First, Midd	lle, Last)								MONT	OF DEATH	W		3. TIME OF DEATH
	- 1	EARL	-				NES					DBER]	Ï3 1	995	1:01P w
	- 1	4. SOCIAL SECURITY NUMBER		SEX	yrs. lest birthday) K YRS.	MONTHS DAYS			24 HRS. MIN.	7. DATE	of BIRTH	0/18		LACE (State or Foreign YLAND	
pinous	ļ	21e 454-6376 9e. FACILITY NAME (If not institution		XM 2 F	40	O This.	9b, CITY, T	COMMIN CO	IR LOCATIO	ON OF DE		• 2/, 1	_	NTY OF DE	
3 sho	Œ	JOHNS HOPK			7\ T		BAL						9t. COU	n/a	Sin.
1, 2,	CTO	RESIDENCE OF DECEDI	ENT	OSFII	ATI					C1.	1 1		L	11/ α	
Pages	IRE	MARYLAND 10b.	COUNTY	/a		10c, CI	Y, TOWN OR BALT			CITY					tod. INSIDE CITY LIMITS?
permit.	LDI	10e. STREET AND NUMBER		, <u> </u>				_	. ZIP CODI				100 017		XX YES 2 NO
ISIL	FUNERAL	2016 ORLEA				. ZIP CODI	212	31	UNITED S			TATES			
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. The director of the control of the	BY FUN	t1. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced		WAS DECEDEN FORCES? 1 IF YES, GIVE W UNK.			11:	yes, spi		m, Mexica	n, Puerto	N? (Specify Yes Rican, atc.)	or No-		- American Indian, White, etc. black
r attend use as	ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working													
for u	LET	Elementary/Secondary (0-12)	1	College (1-4 or 5+) life. Do NOT us			se retired.)							, , do ,	
he hospit detached once.	OMPL	10 th 17. FATHER'S NAME (First, Middle,	1000			LAB	ORER					variou		rades	
be der	0	CHARLES	JONES						18. MOT		ROTH	Middle, Maiden	BERT	S	
5 should 1	BE	t9e. INFORMANT'S NAME (Type/P				19b. MAILIN	ADDRESS (Street e	nd Number			ber, City or Tow	_		
ay be reta page 5 sh	10	DOROTHY	JONES			208	SIL		_	RT,	BALT	IMORE,		2123	
age 6 may director, pa or must b		20a. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 4 Donation 6 Other (Spec	☐ Removal	from State	20b. P	ARRISON	of disposit On Cen	ION TE LE	= 5 y _	CEN	DA1	19 95	ansdo	City or Town	n State
Page al din		21. BIGNATURE OF FUNEBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
ter death. P. the funeral oval.		WM. C. MARC H FH1101 E. NORTH A VENUE													
with the spletch fill cremation rent, the	ERTIFICATION	23. PART I. Enter the disease shock, of heart IMMEDIATE CAUSE (Finel disease or condition reculting in death)	faliure. List	Blun	⊢ /	ch line.	inju								Approximate Interval Between Onset and Death
ertificate be execu- ing physician and rgiene prior to bur other traumatic		Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEDUENCE OF): DUE TO (DR AS A CONSEDUENCE OF):													
the death of the attend d Mental Hy Injury, or	O		d						-	- 1-					+
that bd by h an	MEDICAL (In the underlying ceuse given in Pa					I. 246. WAS AN AUTOPSY PERFORMED? 1 OYES 2 NO			24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\) NO				
law has be Dept.	AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
N: The state State	SICI	EXAMINER?	H	OSPITAL:			OTHER:		- 5 D B	neldages	# [] Oth	as (Specific)			
SICIA certif	PHYSICIAN:	27. MANNER OF DEATH	123	Minpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 ☐ Nursing Hot 286. DATE OF INJURY 28b. TIME OF 28c. IN					URY AT	asioenca		SCRIBE HOW I	NJURY OC	CURED	
G PHN er this tth with	ВУ Р	1 Natural 5 Pend 2 Accident Inves	ling tigation	(Month, E	12-6	1 1 1 1	HO M		YES 25	MD ND	Si	wiech	LII	- on	head
R. After des		3 Suicide 8 Coul	d not be	28e. PLACE C building,	atc. (Specifi	— At home, farm,		ry, offic	•		26f. LOI City	CATION (Street of or Town, State)	end Numbe	or Rural Ro	oute Number,
TECTO TECTO TITS aft	ETE		mined	L	K	oadu	16	_			50	oblk	N.	Made	eria Ballon
SPITAL DI NERAL DI hin 72 hox NT: If ite	COMPLET	ana)				dge, death occur and/or investigat									and menner ee stated.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires TO THE FUNERAL DIRECTOR: After this certificate has been signs be filed within 72 hours after death with the State Dept. of Healt IMPORTANT: If item 28 is marked, or item 23 shows a	BE	29b. SIGNATURE AND TITLE OF	CERTIFIER	gr.	14		•			C.M					
1,	10	30. NAME AND ADDRESS OF PER	R P	OLA COL	ISE OF DEAT	TH (ITEM 27) (799	Penn	St	tree	t,	Bal	timor	e, M	laryl	and 21201
+1		31. DATE FILED (Month, Day Your OCT 1- / 1995	Juli	32 REGISTRA	AR'S SIGNA	TURE									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

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BALTIMORE, MARYLAND 21215-0020

	FOR	PART I, 27, STATE OF MAR									E					
	1 - STATE REGISTRAR	011112 01 1117111			ICATE				MEN IN	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATN		WELL	3. TIME OF DEATN			
	ANGELA ROMAIN	E HOPPS	S	J	OHNS	SON			OCT		AY 1.0	YEAR 95	0547 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTN	• -	8. BIRTN	PLACE (State or Foreign			
	219-50-0758	1 M 2 XX	47	YRS.	MONTHS	DAYS	HOURS	MIN.	MAY	5,	1948	BA	LTIMORE, MD			
	9a. FACILITY NAME (If not institution, give street	ot and number)			9b. CITY,	TOWN O	R LOCATIO	ON OF DE				NTY OF D				
DIRECTOR	2017 SWANSEA RO	AD			BALT	CIMC	ORE	CIT	Y	<u>-</u>		n/a				
낊	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCATI	ION	-					10d. INSIDE CITY			
붑	MARYLAND	n/a			BALT	IMOR	₹E						LIMITS?			
	10e. STREET AND NUMBER					10f.	ZIP CODE				10g. CIT	IZEN OF V	VHAT COUNTRY?			
ER.	2017 SWANSEA ROAD 21239 UNITED															
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE			13, V	MAS DECI	ENDENT C	OF NISPAN	VIC ORIGIN	i? (Specify Ye	or No-	14. RACE	American Indian.			
	1 Never Married 2 Married	FORCES? 1 Y	ES 2XX	10	l II	f yes, spe	city Cube		n, Puerto	Rican, etc.)		Black	t, White, etc.			
B	3 Widowed 4 Divorced	11 120, 0172 1541 0	M DAILS		'	1E3	2XXN0	Specin	у.			Speci	* BLACK			
品	15. DECEDENT'S EDUCA	TION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	PN .		16b	KIND OF BU	SINESS/IN	DUSTRY				
ᇤ	(Specify only highest grade co	College (1-4 or 5+)	lite.	Do NOT u			st of workin									
립	12 th	-	N	URSES	S A	IDE		+		HOS	PITAL	-				
COMPLET	17. FATNER'S NAME (First, Middle, Last)						18. MOTI			Middle, Malden						
ш	RAYMOND E. H	HOPPS				- 4		LOU	ISE	DIXO	N					
8	19a. INFORMANT'S NAME (Type/Print)		198		ADDRESS	(Street ar	nd Number	or Rural	Route Num	ber, City or Tow	m, State, Zi	p Code)	1 01007			
2	LOUISE HOPPS			3704	4 f	erno	dale	a	venue	e, bal	timo	re, n	nd 21207			
-	20a, METHOD OF DISPOSITION		20b. PLACE				me of		DAT	E 20c. LC	CATION -	City or To	wn, State			
	1 X Puriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	al from State	Cemetery Cre	Gastory or o	YEMOR	IAL	PAF	RK	10-20	RA	NDALI	STO	NN, MD			
	21. BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY															
	1	to K	has		la la	IM (^ M/	ΔRCH	FH.	-1101	F	NORTH	AVENUE			
	1 mell		Jura	00												
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis	st Only Dne cause D	ased the de on eech line	ath. Do	no1 en1ar	tha mo	de of dy	Ing, suc	h aa can	diac or reap	iratory ar	reat,	Approximata Interval Between			
1 1	IMMEDIATE CAUSE (Finel	100									Onset and Death					
	disease or condition resulting in deeth) e.	HEAD INJUR														
	DUE TO (OR AS A CONSEQUENCE OF):															
Z	Sequentially list conditions, b. Dur 70 con as a coursely year on															
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING															
길	CAUSE (Diseese or Injury C.	DUE TO (OR /	AS A COMPE	DUENCE O	en.											
<u>E</u>	that initiated events resulting in death) LAST	DOE TO (OR)	AS A CONSEC	DOENCE U	r):											
빙	d.			_									<u> </u>			
انا	PART II. Other algnificent conditions	contributing to dear	th but not r	resulting	In the un	derlying	ceuse	given in	Part 1.	24a, WAS AN		24b	WERE AUTOPSY FINDINGS			
MEDICA										PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE			
									_	TWESTES .	Z NO		OF DEATH? 1 ₩ YES 2 □ NO			
Σ	DID TOBACCO USE CONTRI	BLITE TO CALISI	E OF DEA	TH V	ES [] N	in to	LINIC	ERTAI	N D				TES 2 NO			
A A	25. WAS CASE REFERRED TO MEDICAL	BOIL TO CAUSE			TN (Check o		1 0140	LKIA	1							
SICIAN:	EXAMINER?	HOSPITAL:			OTHER	R:										
l ≥	1X YES 2 □ NO 1	28e. DATE OF INJU		26b, TIN	_	ing Nome		aaldence	6 Othe		101 1111111 011	-				
PHY	1 Netural 5 Pending	(Month, Day, Ye	ear)	IN.	JURY	WO	RK?	VI 110		ed. DESCRIBE NOW INJURY OCCURED						
B	2 XXAccident Investigation 10/12/95 10:00 PR 1 725 4X NO SU									JECT FEI						
品	3 Suicide 6 Could not be 4 Nomicide determined	building, etc. ((Specify)			ory, ome			City	or Town, State	2017	SWANS	Poute Number, EA ROAD			
III	20. CERTIFIED			RESID						BALTIMORE, MD. 21214						
COMPL	29a. CERTIFIER (Check only one)															
ő	2 MEDICAL EXAMINER:	On the beals of examin	nation end/or	investigati	on, in my o	pinion, d	eath occu	red at the	time, date	end place, a	nd due to t	he cause(a) and manner as stated.			
ш	29b. MONATUME AND TITLE OF CERTIFIER	0/					29c, LIC	ENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)			
00	mouling, the	Shill					0.0	C.M.	E.		10	CT.	13. 1995			

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MARLAND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM MARLAND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM ADDRESS OF DEAT

Penn Street, Baltimore, Maryland 21201

Pages 1, 2, 3 should

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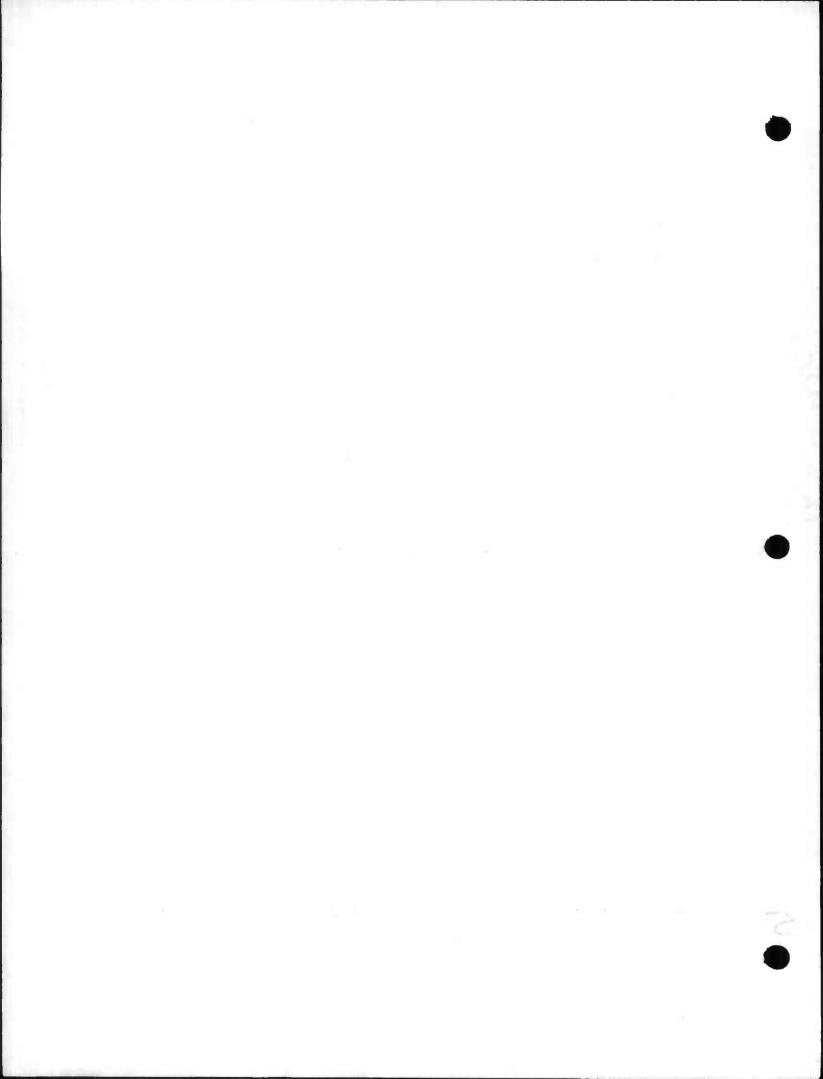
funeral filled in by the finan or removal. and com executed the attending physician Mental Hygiene prior to OR ATTENDING PHYSICIAN: The law requires that the death certificate be and and signed b t of H certificate has be DIRECTOR: After the hours after death v

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH ~13,1995 OCTOBER " P .M **JONES** 6:16 KENNETH 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 6. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. 1947 47 1 XW2 F 18-42-9548 Dec. 17, MD 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR 828 REVERDY ROAD BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10b. COUNT 19c. CITY, TOWH OR LOCATION 10a. STATE 10d. INSIDE CITY MD n/a Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 828 Reverdy Rd. 21212 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 14 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Bleck, White, etc. If yes, specify Cuben, Maxican, 1 YES 2 PNO Specify: 1 Never Married 2 Micried Specify: Black BY 3 Widowed 4 Divorced 7/2/70-7/2/71 16a. OECEDENT'S USUAL OCCUPATION

The desired dame during most of working ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL emble General Motors 4 yrs man once. 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Obadiah Jones 픁 Dorothy Shingfield BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Theresa Jones 828 Reverdy Rd. BAlto., MD 21212 Pe 204 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Garrison Forest VA 4 Donation 5 Other (Specify) 10/1B Owings Mills, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Homes W. on 1701 Laurens St. Balto., MD 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiac or respiratory streat, about, or heart failure. List only one cause on each line. 21217 medicai Approximata interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition Arteriosclerotic Cardiovascular Disease resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TYES 2 1 NO Shows INSPECTION 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 23 26. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL ltem! OTHER:
4 □ Nursing Nome 5 Residence 6 □ Other (Specify) of this cer.
The with the Star. HOSPITAL: XXYES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK?
1 YES 2 NO 26b. TIME OF 26d. DESCRIBE NOW INJURY OCCURED marked, 1 X Natural 5 Pending Investigation BY 2 Accident 25a. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number City or Town State) 60 6 Could not be COMPLETED 4 Nomicide 28 Hem 29a. CERTIFIER

(Chack only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 MINIMARTANT. IF IN 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND THILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCTOBER 14,1995 O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) DAVID FOWLER MD. 111 Penn Street, Baltimore, Maryland 21201

REDISTRAT'S SIGNATURE



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RECORDS, P.O. BOX 68760	certificate
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DIVISION OF VITAL	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: 24 hours
S	DING P
2	ATTEN
5	DR
	SPITAL

	REGISTRAR		RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.									
	1. DECEDENT'S HAME (First, Middle, Lest) THOMAS 4. SOCIAL SECURITY HUMBER 5. SEX			2. DATE OF DEATH DAY OCTOBER 12									
	218-28-0368 1 🖾 M 2 [F UNDER 1 YEAR F UNDER 24 HRS MONTHS DAYS HOURS MIN.	49.4 44 49 44 4	8. BIRTHPLACE (State or Foreign Country) SCOTLAND								
CTOR	96. FACILITY HAME (# not institution, give street end number) NORTH ARUNDEL HOSPITAL 90. COUNTY OF DEATH GLEN BURNIE ANNE ARUNDEL												
DIRECT	10a. STATE 10b. COUNTY MARYLAND ANNE A		TY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS?								
FUNERAL	100. STREET AND NUMBER 805 BUNCH AVENUE		101. ZIP CODE 21060	109	1 TYES 2X NO 3. CITIZEN OF WHAT COUNTRY? U.S.A.								
BY FUNI	1 Never Married 2 Married FORCES	EDEHT EVER IH U.S. ARMED 1 YES 2 NO IIVE WAR OR DATES	13. WAS DECENDENT OF HISI It yee, specify Cuben, Mex 1 YES 2 NO Spe		14. RACE — American Indien, Black, White, etc. Specify: WHITE								
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give kind of	S USUAL OCCUPATION work done during most of working use retired.)	16b. KIND OF BUSINES									
at once.	10 N/A 17. FATHER'S NAME (First, Middle, Lest) JABEZ	JORE	18. MOTHER'S		PROCTOR & GAMBLE AME (First, Middle, Melden Surneme) BOTT								
be notified TO BE	19a INFORMANT'S HAME (Toro(Drine)												
, cremation, or removal event, the medical examin	23. PART L Enter the diseases or complication shock, or heart failure. List only on IMMEDIATE CAUSE (Final disease or condition resulting in death)	ceuse on eech line.	not enter the mode of dying, so	SINGLETON NUE, S.W., GL	N FUNERAL HOME, EN BURNIE, MD.21 Ty arrest, Approximata interval Betwee Onset and Dei 3 Mow?								
or other traumatic	disease or condition resulting in death) Sequentielity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ASSIMACEM Cancer 34000000000000000000000000000000000000												
ws any in	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WER												
AN AN	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRIDED MEDICAL EXAMINER?	26. PLACE OF DEA	ES NO UNCERTA		1 YES 2 MO								
or H	1 YES 2 NO 1 Inpution 27. MANNED-OF DEATH 28e. DA	2 ER/Outpitlent 3 DOA E OF IHJURY 28b, TII	OTHER: 4 Hursing Homa 5 Residence WE OF 28c, INJURY AT										
is marked,	Natural 5 Pending 2 Accident Investigation 2 Republic	nth, Day, Year) IN	JURY WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number.									
m 28	4 Homicide determined	ding, atc. (Specify)		City or Town, State)									
2 = 5	(Check only one) 2 MEDICAL EXAMINER: On the bash	of examination end/or investigati		ne time, dats end place, end due	to the cause(s) and manner as stated.								
IMPORTANT: TO BE CO	296. SUPPLETURE AND TITLE OF CERTIFIER Schulfe	derny	29 LICEHSE N	UMBER 29d. ▶	BULNIE MANY 21061								
	DAV H, SCHAR BE	CAUSE OF DEATH (ITEM 27) (Type)	HOSPITAL DA	rul, blen	BUNIE, MANY								
	OCT 1 7 1995 Jaly 32 Alex	TRAR'S SENATURE			21061								

	ITEM: 20b, PER F.H. FI	LM G-728 10/17 STATE OF MARYL		RTMENT	OF HE	INA HTIA	MENT/	AL HYGIENI	F					
	1 - STATE REGISTRAR	OME OF MATTE	CERTIF				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest) EDITH	М.		KI	ENNY		2. DAT MON	OCT.	9th	199	5 11:45 F			
	4. SOCIAL SECURITY NUMBER 233 34 6208	1 - M 2 X F	(In yrs. last birthday) O YRS.	MONTHS	DAYS	HOURS MIN	Jul	E OF BIRTH oth, Day, Year) Y 1, 19	8. BIRTNPLACE (State or Foreign Country) West Virginia		Virginia			
10R	NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUNTY RESIDENCE OF DECEMENT													
DIRECTOR	10a. STATE 10b. COUNTY Maryland n/a			TY, TOWN O		ON					d. INSIDE CITY LIMITS? YES 2 NO			
ERAL	10e. STREET AND NUMBER 4110 Daune Avenu	ue	•		10f, :	ZIP CODE 21225				S.A.	T COUNTRY?			
BY FUNER	1t. MARITAL STATUS 1 Never Married 2 Merried 3 X Wildowed 4 Divorced	12. WAS DECEDENT EVER I FDRCES? 1 YES IF YES, OIVE WAR OR D	2 X NO		If yes, spec	NDENT DF NIS city Cuban, Mer 2 1 NO Sp	ilN? (Specify Yea o Rican, etc.)							
ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a. DECEDENT' (Give kind of We. Do NOT	work done			16	Sb. KIND OF BUS	SINESS/INDU	ISTRY				
COMPLET	8th	ounder (1 4 di 6 4)	Home	Maker		J. L		Own Ho	ome					
	17. FATHER'S NAME (First, Middle, Lest)	avman Schre	owshurv					, Middle, Meiden						
TO BE	19a. INFORMANT'S NAME (Type/Print) Patricia Baca										1225			
TO BE	20a. METHOD OF DISPOSITION 1 Surlai 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of CAFFEY Cemetery) DATE 20c. LOCATION - City or Town, State 10/13 Beckley, West Virgin													
	21. SIGNATURE OF FUNERAL SERVICE LICE		uly -	22. Ge	NAME AND		racility once I	Funeral	Home	P.A.				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, international disease or condition resulting in death) a. 4001 Ritchie Hwy. Baltimore, Md. 212 Approximately a such as cardiac or respiratory arrest, international disease or condition resulting in death) a. Feature 1001 Ritchie Hwy. Baltimore, Md. 212 Approximately 1002 Approximately 1003 Approxim													
RTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE A CONSEQUENCE A CONSEQUENCE	OF):	~(110	VII-					Few how			
N: MEDICAL CER	Demartia,	grantist	ong tu	tube mishin PERFORMED? 1 yes 2 gro							ERE AUTOPSY FINDING: ALLABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL	26. PLACE DF DE	ATN (Check										
	1 YES 2 ND 27. MANNER OF DEATN 1 Netural 5 Pending	1 Impatient 2 Impa	26b. T			RIC?	-	ther (Specify) DESCRIBE NOW I	INJURY OCC	URED				
TED BY PI	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE DF INJUR building, atc. (Sp		, street, tac		2 2 110		OCATION (Street : ity or Town, State)	(Street and Number or Rural Route Number, n, State)					
BE COMPLET	onei only	CIAN: To the best of my kno									nd manner as stated.			
O BE C														

SYED M. RIAZ
31. DATE FILED (Month, Day, Year)

OCT1 71995

M.D./800 N HAMMONDS FERRY ROAD/LINTHICUM, MARYLAND 21090

32. BEGISTRAR'S SIGNATURE

LLON-ROALL

RIAZ,

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

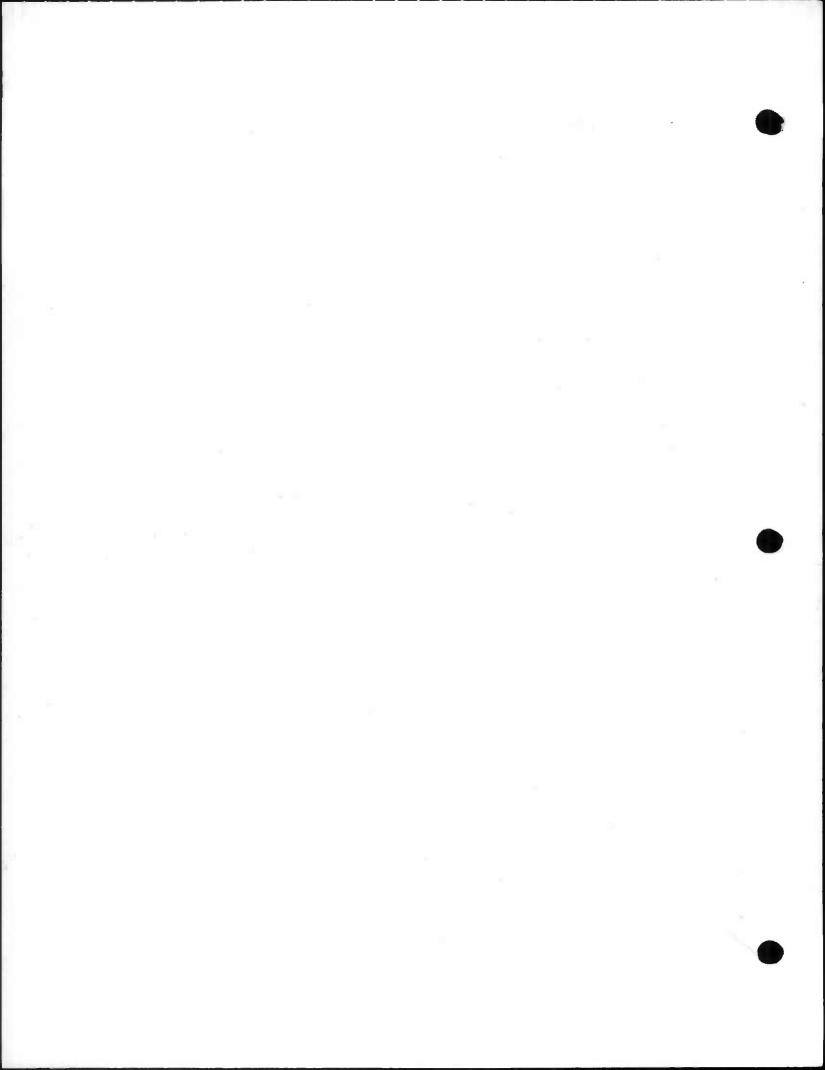
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MANTH															
	MYRTHE KELLY MYRTLE GRACE KELLY										OCTOBER 144-1995 1 . 15 A					
	4. SOCIAL SECURITY NUME	5. SEX	last birthday)						OF BIRTH	7	8. BIRTHP	LACE (State or Foreign				
	220 05 922	1 □ M 2 💢 F	YRS.	MONTHS	DAYS	AYS HOURS MIN.			19,	1907	Country)	ryland				
	90. FACILITY NAME (If not in					96. CITY, T			ION OF D	_		9c. COU	NTY OF DEA	-		
DIRECTOR	Harbor H	Harbor Hospital Center Baltimore N/A														
EC	10e. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN OR	LOCAT	ION						IOd. INSIDE CITY		
	Maryland		iviera								LIMITS?					
FUNERAL	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CITI	ZEN OF WH	IAT COUNTRY?		
Ä	8426 Park	Road					21	122			Ţ	J.S.A.				
5	11. MARITAL STATUS 1 Never Married 2	Merried		YES 2	ARMED XNO	13. WA	S DEC	ENDENT	OF HISPAI	NIC ORIGIN?	(Specify Yes	or No-	14. RACE - Black,	- American Indian, White, etc.		
ВҰ	3 🔀 Widowed 4 🗌 Divo		IF YES, GIVE V	WAR OR DATES		10	YES	2 X NO	Specif	ly:	,		Specify:	White		
	15. DEC (Specify only	EDENT'S EDU	CATION completed)		DECEDENT'S (Give kind of	work done dur	UPATIO	ON st of world	ina	16b.	KIND OF BU	SINESS/INC	DUSTRY			
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	•)	Iffe. Do NOT us	se retired.)										
COMPLETED	8th 17. FATHER'S NAME (First, M	Note to a			Home N	aker					Own H					
	12. PAIRER S NAME (PISt, M		Charles	Craig				18. MOT	HER'S NA		iddle, Meiden Bradey	and the same of				
TO BE	190. INFORMANT'S NAME (7			Ť	19b. MAILING	ADDRESS (S	Street a	nd Numbe			w, City or Tow	n, State, Zip	Code)			
F	Bernard F				8426				Ri	viera	Beac	h, Ma	aryla	nd 21122		
		20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wester								10/1			City or Town			
	21. SIGNATURE OF FUNERA		ENSEE	22. NA	22. NAME AND ADDRESS OF FACILITY						Baltimore, Maryland					
George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md.																
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate															
- 1	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Desth															
	disease or condition resulting in death)	→	Cong	CARE	DIAC F	LUR	E: (CAD								
- 1	a. CONGESTIVE CARDIAC FAILURE; CAD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b. IDOM C PERIPHERAL VASCULAR DISEASE															
ON	Sequentially list conditi		DUE TO	(OR AS A CONS	YERIF SEQUENCE OF	HERA	2	VAS	CULA	IR L	DISEA	SE				
SAT	if any, leading to Immedicause. Enter UNDERLYI	NG	~			HYPERTENSION ENCE OF:							i			
Ĕ	CAUSE (Disease or Inju that initiated events					_										
CERTIFICATION	resulting in deeth) LAS	'	UTI	CHRO	HRONIC RENAL FAILURE											
	PART II. Other aignifice	nt condition	a contributing to	deeth but no	t reaulting	in the unde	riying	cauee	given in	Part i.	24a. WAS AN			PERE AUTOPSY FINDINGS		
MEDICAL							_	PERFOR		C	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
ME														YES 2 NO		
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒															
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PL	ACE OF DEAT	H (Check only	(one)									
₹	1 YES 2 NO		1 1 Inpetient 2			4 - Nursing			esidence							
BY P	1 Netural 5	Pending Investigation	28e. DATE OF (Month, D	ey, Ybar)	26b. TIM INJ	URY	WO	URY AT RK? 'ES 2	NO	28d, DE\$C	RIBE HOW II	NJURY OCC	CURED			
	3 Suicide 6	home, farm, s	Hreet, fectory	, office			28f. LOCATION (Street and Number or Rural Route Number, City or Town: State)									
ETED	an accrece	4 Homicide determined City or Town, State)														
COMPL	(Check only 1 22 CERT		CIAN: To the best of											A		
	2 MEDICAL EXAMINER: On the beets of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
H	Masta	Culabi	,	RN, HA	BRAD H	nco len	TER	In .	ENSE NUN					fonth, Day, Year)		
임	30. NAME AND ADDRESS OF	011						713	246	116/4	1-51	- 00	tober	14 1995		
	MEETA CUI	ITI Pr	NYI DEP				ARI	ROP	Has	PITA,	(FAT	TEO	RA	TIMORE		
	31. DATE FILED MOOTE DOLL	100E						010	1103	1.116			1.015	- 117.0/2		
	20111	1333	Jeli de	tolen-Ran	dall											

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDIF	TO THE FUNERAL DIRECTOR: After this of the filed within 72 hours after death with	IMPORTANT: If item 28 is i

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF I	EALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	FRANK A. KUNKOWSE	ΚI					3 1995			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. B	IRTHPLACE (State or Foreign		
- 1	219-01-3317	1 🔀 M 2 🗆 F	77 YRS.	MONTHS DAYS	HOURIE MIN.	NOV 18 1		ARYLAND		
	9a. FACILITY NAME (If not institution, give at	reet and number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY O			
O.	812 ANDOVER RD			LINTHIC	UM		ANNE A	ARUNDEL		
딦	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	40e CITY	TOWN OR LOCA	1011					
DIRECTOR		ARUNDEL		HICUM	ION			10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	MONDEL	LLINI		. ZIP CODE		100 CITIZEN	1 YES 2X NO		
E.	812 ANDOVER RD			15	21090			10g. CITIZEN OF WHAT COUNTRY? USA		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT_EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Ye				
	1 Never Married 2 Married	FORCES? 1 [X] YES IF YES, GIVE WAR OR DA		If yes, sp	ecify Cuban, Mexica 2 NO Specif	en, Puerto Rican, stc.)		RACE — American Indian, Black, White, atc. Specify:		
BÁ	3 Wildowed 4 Divorced	WWII				,		ITE		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DECEDENT'S L	ork done during mo	ON at of working	16b. KIND OF BU	SINESS/INDUSTR	TY .		
ا چ	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ime. Do NOT use	retired.)						
Ž	17. FATHER'S NAME (First, Middle, Last)		SELF E	MPLOYED		BAR & R		NT		
	STANISLAV KUNKOWS	!VT				ME (First, Middle, Maiden	Sumame)			
BE	19a. INFORMANT'S NAME (Type/Print)	KI	19h MAILING	ADDRESS /Street		JCIECOWSKI Route Number, City or Tow	on Other Will Control			
2	KLARISSA BLATNEY					RNIE, MD 2)		
	20a, METHOD OF DISPOSITION	20b.	PLACE AND DATE OF				CATION — City of	r Town State		
	1 N Buriel 2 Cremetion 3 Remo	oval from State ceme	otery, crematory or oth	er place)		1				
	21. SIGNATURE OF FUNERAL SERVICE CTC	ENSEE	OWINDVILL	22. NAME AI	D ADDRESS OF FA	CILITY		E, MARYLAND		
	1 10 / A	EXALL				NK FUNERAL		ND 01061		
\dashv	23. PART I. Enter the diseases, or c	complications that fausact	the death. Do no	1420 C.	de of dulps, eve	SW GLEN B	URNIE,	THE PARTY NAMED OF TAXABLE PARTY.		
	anock, or naart failure.	Liat only one cause on ea	ch line.	A GINGI (IIG IIIC	da or dynig, suc	ii aa cardiac or resp	A arrest	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	V	OU.	- 1/0	1.A.	. 0 .	La. De	UCLI K UT		
ı	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	- A	MINI	algo	/ m m	no year		
z I	Hyserheusen - 1-3									
RTIFICATION	Sequentially list conditions, If any, leading to immediata									
2	CAUSE (Disease or Injury	DUE TO (OD 40 A	001050151105.00							
	that initiated events resulting in death) LAST	DUE TO OR AS A	CONSEQUENCE OF)	•						
		l,						-i		
4	PART II. Other algnificent conditions	contributing to death bu	t not resulting in	the underlying	csuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS		
7 Z III						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC								OF DEATH?		
ż	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIL	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH	(Check only one)						
2	1 VES 2 NO	1 Inpatient 2 ER/Outpa	tient 3 DOA	1 Nursing Hom	5 Residence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY WO	RK?	28d. DESCRIBE HOW I	NJURY OCCURE			
R	2 Accident Investigation	200 DI ACE OF IN HUM	44.5	M 1						
3	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Special	/y)	reet, tactory, offic	1	26f. LOCATION (Street a City or Town, State)	and Number or Ru	ral Route Number,		
4	29a. CERTIFIER									
호		CIAN: To the best of my knowle								
29b. SIGNATURE AND TITLE OF CERTIFIED 29c. Cutd not be determined 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, 100) 29d. LICENSE NUMBER 29d. DATE SIGNED (Month, 100) 29d. LICENSE NUMBER 29d. DATE SIGNED (Month, 100)										
							- Control Income			
2 ∦	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) /Tone 1	Print)	101	800	10-16	95		
					TE MO	1061				
ŀ	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNA	E HWY GL	EN ROKN	IE, MD 2	1001				
	OCT 1 71995 Jul	in dhudson had	e the							



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NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	Ather this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3	death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	s marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
 The law requires that the death certificate be exe 	cate has been signed by the attending physician an	State Dept. of Health and Mental Hygiene prior to b	Item 23 shows any injury, or other traumal
ING PHYSICIAN	Wher this certific	eath with the S	marked, or
무	DR: A	fter d	_
JR AT	MECT	S SINC	item 28
TAL	PAL D	2	=
THE HOSPITAL DR ATTER	FUNEF	led within 72	TANT
THE OF	TO THE	be filled	MPOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 oct. 15, Alice May King 1:35 PM 8. BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5 SEX 8. AGE (in vrs. lest birthdev) IF UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year)

April 30, 1911 Pennsylvania MONTHS DAYS HOURS MIN 1 🗌 M 2 🗶 F YRS. 84 213-28-7650 9c. COUNTY OF DEATH Se. FACILITY NAME (If not institution, give street end number, 95 CITY TOWN OR LOCATION OF DEATH Ivy Hall Geriatric Center Baltimore DIRECTOR Middle River 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Essex Maryland Baltimore 1 YES 2 KNO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10e STREET AND NUMBER 10f. ZIP CODE U.S.A. 7 "E" Norham Court 21221 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2, If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Merried 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementery/Secondery (0-12) College (1-4 or 5+) Own Home Housewife 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Alice P. Neider BE Arthur Watt 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 7 "E" Norham Court Essex, Maryland 21221 Joan A. Murphy 20b. PLACE AND DATE OF DISPOSITION (Name of 10/18/b1799 Spc. LOCATION — City or Town, State HOLLY HILL Mem. Gardens Baltimore, 20e. METHOD OF DISPOSITION

120 Burtel 2 Cremetion 3 Removal from State Baltimore, MD. 4 Donetion 5 Other (Specify) 21, SIGNATURE OF FUNERAL PRIVICE LICENSEE Bruzdziński Funeral Home P.A. 1407 Old Eastern Ave. Balt., MD. 21221 23. PAHT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line Onest and Death IMMEDIATE CAUSE (Final disease or condition 20 yrs. Emphysema reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Cerebrovascular Accident 1 🗌 YES 2 🙀 NO 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐ 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER: 1 YES 2 X NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 🛣 Nursing Home 5 □ Residence 8 □ Other (Specify) 27. MANNER OF DEATH 28e DATE OF INJURY 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED 28b TIME OF INJURY 1 X Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homfolde determined 29e. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. 2 MEDICAL EXAMINER: On the beele of exam mination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner as atated 29c. LICENSE NUMBER 29b. SIGNATURE AND TITLE OF CERTIFIER 29d DATE SIGNED (Month Day Year) BE

8022 Belair Rd.

D17728

Balto., Md.

M.D., 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE OCT 1 71995 Studen Redall

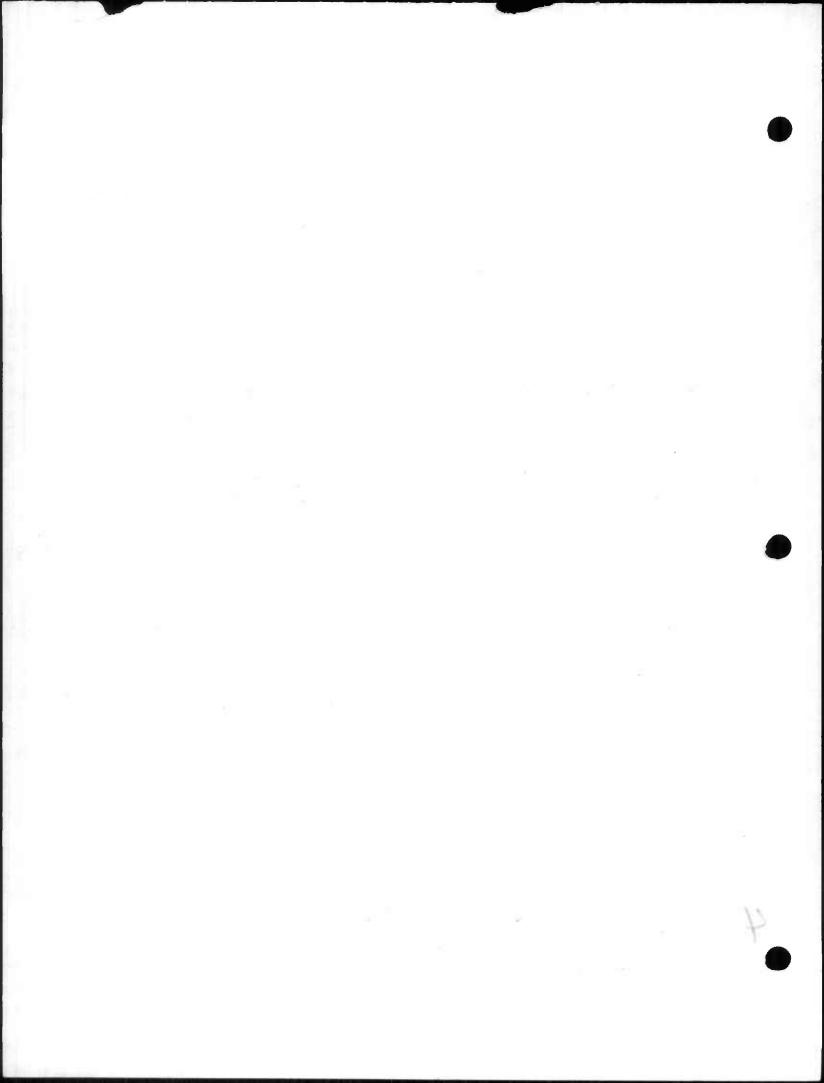
Ba Yin Oung,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

10/16/95

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	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH A	AND MENTAL HYGIE H REG. N				
1	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH	DAY YEAR	3. TIME OF DEATH		
1	Mary E. Klebes				Oct. 12	, 1995	5:20p		
	4. SOCIAL SECURITY NUMBER 161-01-5029		84	F UNDER 1 YEAR IF UNDER 24 ONTHS DAYS HOURS	(Month, Day, Year)	Cou	TTHPLACE (State or Foreign untry)		
	9a. FACILITY NAME (If not institution, give :	41	70	b. CITY, TOWN OR LOCATION		1917 P€	ennsylvani		
TOR	Knollwood Manor	Nursing	1	Millersvil	le	Anne	Arundel		
DIRECTOR	MD 10b. COUNT Anne	Arundel		TOWN OR LOCATION lersville			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
AL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
FUNERAL		Cecil A		21108		USA			
BY FUI	11. MARITAL STATUS 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO		HISPANIC ORIGIN? (Specify Mexican, Puerto Rican, etc.) Specify:	191	ACE — American Indian, lack, White, etc.		
	15, DECEDENT'S EQU	I CATION	16a, DECEDENT'S US	NIAL COCUMITION	140, 400,000				
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed)		rk done during most of working	16B. KINO OF I	BUSINESS/INDUSTR			
립	9	College (1-4 or 5 +)	Manager	r	Foo	d Servi	.ce		
COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTHE	R'S NAME (First, Middle, Maid	len Sumeme)			
BE (William E. Finl	cler		Ann	ie Fahl				
10 E	19a, INFORMANT'S NAME (Type/Print)	1.			Rural Route Number, City or 1				
-	Kathleen L. Gea				ge Rd. Ode				
	20a. METHOD OF DISPOSITION 1	noval from State	b.PLACE AND OATE OF metery, crematory or otha Nhitemar:	DISPOSITION (Name of Shapes) Shapes Memoria	1 Park 10/1	Prospec	tville, PA		
	21. SIGNATURE OF FUNERAL SERVICE M		11	22. NAME AND ADDRESS	Funeral H				
	1 Oalrick	Il Clark	1	_	ly Ave. An				
	23. PART I. Enter the diseases, or	complications that cause List only one cause on					Approximate		
	IMMEDIATE CAUSE (Finel	Election of Cause of C	A				Interval Between Onset and Dear		
	disesse or condition resulting in death)	· Lung	A CONSEQUENCE OF:			41.7	2,5 man		
		DUE TO (OFFIAS	A CONSEQUENCE OF):						
NO N	Sequentially list conditions,	b. DUE TO (OR AS	A CONSEQUENCE OF:						
AT	If any, leading to immediate cause. Enter UNDERLYING								
H	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST	d							
AL CE	PART II. Other significent condition	ns contributing to deeth	but not resulting in	the underlying cause gi			24b. WERE AUTOPSY FINDING		
OICA	Oh ronie	obst ractio		nary Disea.	PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC	Non In	solin Dehem	dent	Diabetes	14 elle	200	OF DEATH?		
ž Z	DID TOBACCO USE CONT	RIBUTE TO CAUSE O			RTAIN 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	7	-				
YSI	1 TES 2 NO	1 - Inpetient 2 - ER/Out	Ipatient 3 DOA 4		idence 6 Other (Specify)				
РНУ	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME	RY WORK?		W INJURY OCCURED			
BY	2 Accident Investigation	28a. PLACE OF IN HID	Y — At home, farm, atr	M 1 YES 2		et and Number or Rui	ral Bouta Number		
TED	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Spi	ecify)	, warry y william	City or Town, Sti	ate)	a neste tratticei,		
PLET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	wiedge, death occurred	at the time, date and place,	and due to the cause(s) and i	manner as stated.			
COMPL	0001	ER: On the beels of axemination	on and/or investigation,	In my opinion, death occure	d at the time, data and place,	and due to the cour	se(a) and manner as stated.		
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	R		29c. LICEN	ISE NUMBER	29d. DATE SIGN	NED (Month, Day, Year)		
O BE	an			0	28756	10-	13-90		
	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, P	rint)					
F				- 4	_				
ř	Tru-Chunkin	MD. 377-	B Gamb	rille Rd.	Gamprille	140.2	1054		



STATE REGISTRAR

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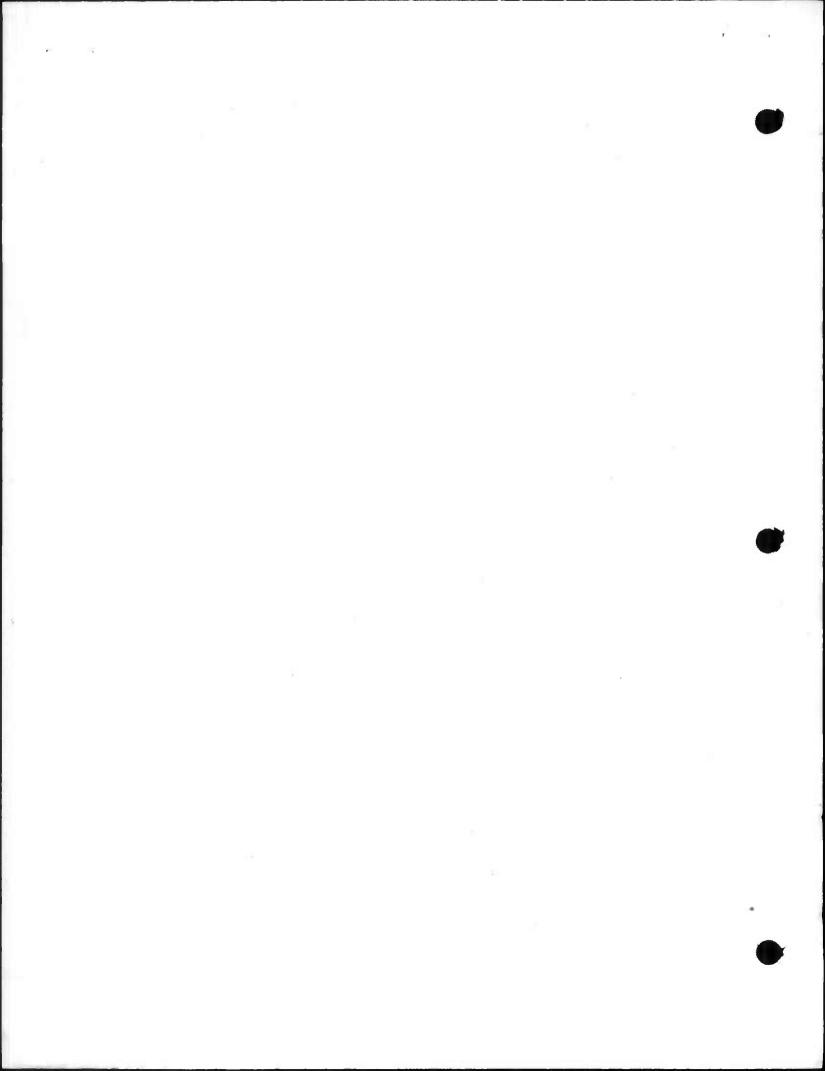
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCTOBER 9 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) BIRTHPLACE (State or Foreign Country) KOREA IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS HOURS 226-43-756k 1 M 2 OCT 18 62 YRS. Pages 1, 2, 3 should FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH N/A DIRECTOR OF DECEDENT ALTMORE 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY BALTIMORE MARYLAND 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21201 1027 CATHEDRAL STREET burial-transit KOREA Page 6 may be retained by the hospital or attending phystician. al director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: KOREAN 3 Widowed 4 Divorced 15, DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL HOUSEWIFE HOMEMAKER 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN notified at UNKNOWN BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1027 CATHEDRAL ST. BALTO., MD. 21201. 19a. INFORMANT'S NAME (Type/Print) 9 KWAN SIK KIM ě 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must funeral director, NATIONAL MEM. PARK 10/95 4 Donation 5 Other (Specify) FALLS CHURCH, VA. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEF 22. NAME AND ADDRESS OF FACILITY
HENRY W. JENKINS & SONS CO. Willian 4905 YORK RD. BALTO., MD. 21212. the medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, and completely filled in by burial, cremation, or remo Approximats shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) Onset and Desth the disease or condition FAIL · MYGCORDIAC resulting in death) traumatic event, AO K DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, prior to t OUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior to if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by the PERFORMED? any BRTWRITES 1 YES 2 NO OF DEATH? shows has been s Dept. of H 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) r this certificate h item OTHER: 1 TES 2 NO Impatient 2 ER/Outpatient 3 DOA ng Home 5 - Residence 8 - Other (Specify) 6 IT MANNER OF DEATH 28s. OATE OF INJURY marked, 28b, TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 - Harting 5 Pending investigation м 1 YES 2 NO OIRECTOR: After the hours after death v BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 69 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 200 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated. TO THE FUNERAL OB be filed within 72 ha IMPORTANT: If IN 2 MEDICAL EXAMINER: On the of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) 8 30142 0 2 LETEO CAUSE OF OEATN (ITEM 27) (Type, Print) 301 50 BALRS 204 40 21808

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



BOX 68760 BALTIMOHE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the foreign of a factor of the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should this State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be exec	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be fled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART				IYGIENE REG. NO.			
	DECEDENT'S NAME (First, Middle, Lest) OLGA B	KOCOPI				2. DATE OF MONTH OC	DEATH DAY	YEAR	3. TIME OF DEATH 2:27 P M	
	183-14-7734	□ M 2 💢 F 7	4 YRS. **	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	FEBRU		PE	NNSYLVANIA	
TOR	98. FACILITY NAME (If not institution, give street NATIONAL NAVAL MI RESIDENCE OF DECEDENT			BETHESDA	EATN		MONTO	GOMERY		
DIRECTOR	10a. STATE 10b. COUNTY	ARUNDEL		ENTON	ATION				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	565 RITA DRIVE				21113		100	J.S.A	• WHAT COUNTRY?	
BY FU	11. MARITAL STATUS 1	FORCES? 1 YES	2 X NO	It yes, s	CENDENT OF NISPA pecify Cuben, Mexica S 2 X NO Specif	en, Puerto Rica		B14	CE — American Indian, sek, White, atc.	
COMPLETED	8		16e. DECEDENT'S U (Give kind of wo life. Do NOT use HOME	rk done during n	ION lost of working		NO OF BUSINESS	INDUSTRY		
BE CO	17. FATHER'S NAME (First, Middle, Lest) PETER	KENDU			ANNA		fle, Maiden Surnam	WA	SYLKIEV	
0	190. INFORMANT'S NAME (Type/Print) HARRY A. KOCOPI									
	20b. PLACE AND DATE OF DISPOSITION 1 Burlel 2 & Cremation 3 Ramoval from State 4 Donation 6 Other (Specify) TOWSON, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061									
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, ahock, or heert feliure. List only one cause on each line.							Approximate Interval Between Onaet and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa reaulting in deeth) LAST	,	A CONSEQUENCE OF)		- 1					
u.J	PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 NO 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 XNO									
PHYSICIAN: MEDICA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
	1 VES 2X NO 1 Inpatient 2 X ER/Outpetlant 3 DOA 4 Nursing Nome 27. MANNER OF DEATN 1 Natural 5 Pending Investigation Investigation						Specify) NBE HOW INJURY	OCCURED		
TED BY	2 Accident investigation 3 Suicide 8 Could not be determined	reet, factory, of	lica		ON (Street end Nur Town, State)	mber or Run	al Route Number,			
ш	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my kno	wlades doeth seeves	et the time d	to and place, and du	e to the cause	(e) and manner ea	at at a d		
COMPLET	(Check only one) 2 MEDICAL EXAMINER:								e(s) end manner as stated.	

NATIONAL NAVAL MEDICAL CENTER

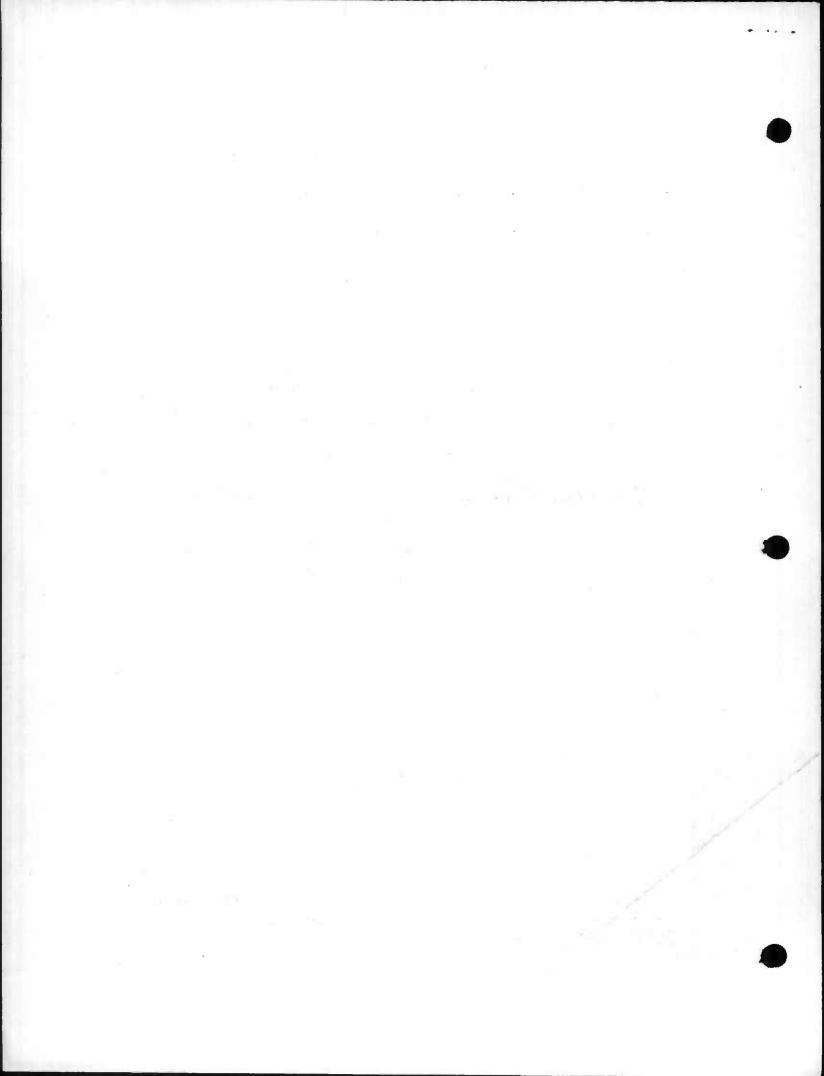
BETHESDA MD 20889-5600



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

T. W. SCHAFER, LT, MC, USN

31. DATE THE MORE OF THE



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MARYLAND 21215-0020	e retained by the hospital or attending
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH aroline Knezevich 440 10 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR a. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 212-05-3365 3-14-04 BAL 1 M 2 F 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTO. DIRECTOR Eastpoint Nursing SALTIMORE DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Essex 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 7 Marie Ave. 21221 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORION? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES ZYN NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 X Widowed 4 Divorced Specify: White ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify or Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 7th Housewife own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Anna T. Dornick BE William J. Wright 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Helen Tirabassi 601 E. Church Hill Road BelairMd.21014 must be 20a. METHOD OF DISPOSITION
1 Carried 2 Comments 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE cometary, crematory or other place)
SacredHeartofJesus 1017/95 4 Donation 5 Other (Specify) Baltimore Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart latitude. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition # CARDIOPULMONARY event, resulting in death) DUE TO (OR AS A CONSEDUENCE OF): ORONARY ARTERT traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEDUENCE OF) if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCTION cause. Enter UNDERLYING CENT CAUSE (Disease or injury that initiated events HYPERTENSION reaulting in death) LAST 6 PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE any DEMEN 1 - YES 2 NO DF DEATH? shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item HOSPITAL OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 ND Inpatient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME DE 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 5 Pending Investigation BY 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28 is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 DECERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

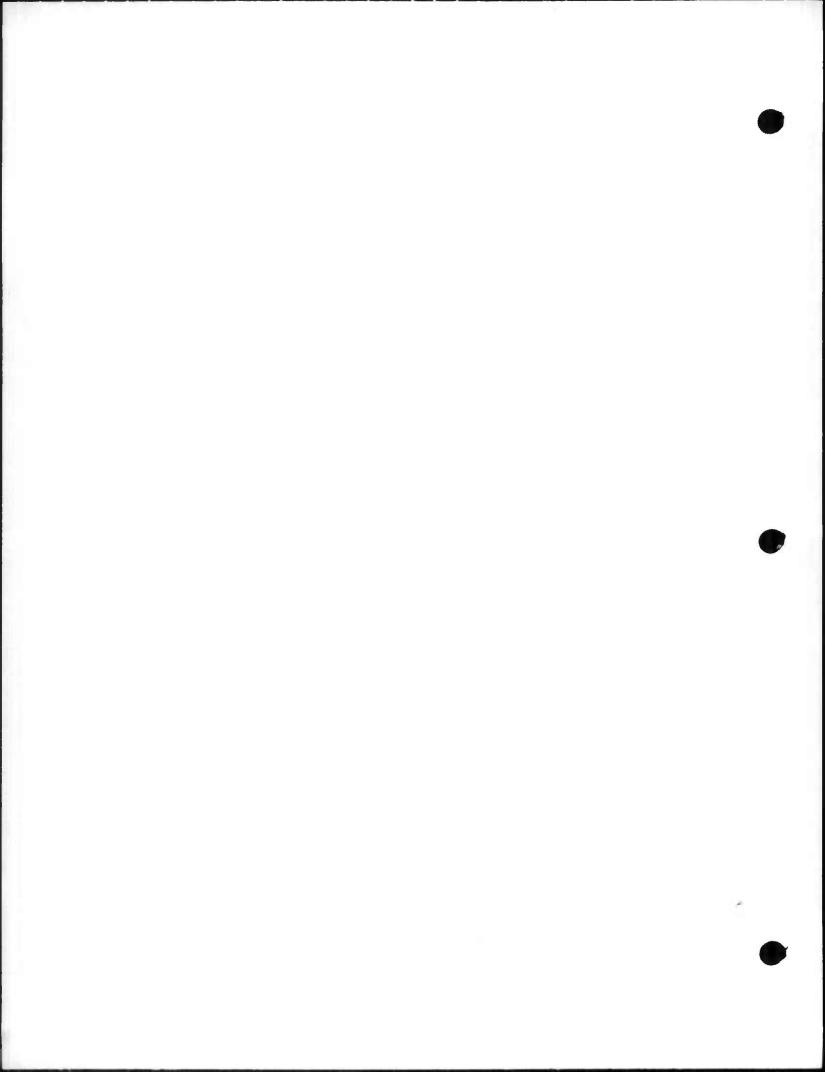
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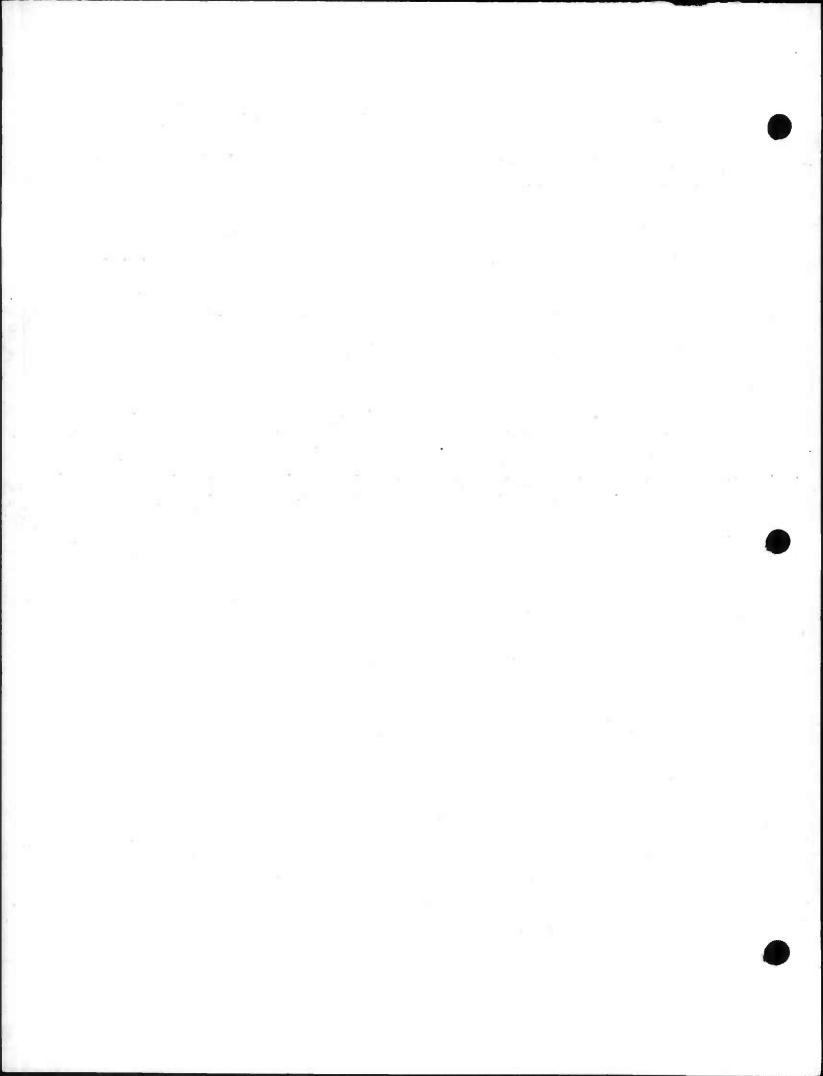
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the med
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 3. TIME OF DEATH DECEOENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH enjamin DAY YEAR Octobe 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign Aufgrith 202 1 901 Russia 578-44-0779 93 1 XM 2 | F 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OEATH Suburban Hospital Bethesda Montgomery DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Rockville Maryland Montgomery 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101 ZIR CODE 10g. CITIZEN OF WHAT COUNTRY? 1801 East Jefferson Street #104 20852 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian. Black, White, etc. FORCES? 1 YES 2 NO t Never Married 2 Married
3 Wildowed 4 Divorced Specify: White 1 YES 2 X NO Specify: BY COMPLETED 15. DECEDENT'S EQUICATION 16a. DECEDENT'S USUAL OCCUPATION 165 KIND OF BUSINESS/INQUISTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Founder Personnel Agency 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pearl Ganz 17. FATHER'S NAME (First, Middle, Last) Louis Kipnis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code) $11521\ Twining\ Road,\ Potomac,\ Md.$ 2 20854 Jeffrey B. Rosenbloom 20c. LOCATION - City or Town, State
Adelphi, Maryland 20a. METHOD OF DISPOSITION
14 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 10-8 Mittary. crepate brain on Cem. 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va. 22046 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. Interval Batween Onset and Desth IMMEDIATE CAUSE (Final disease or condition resulting in death) newnong DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMAIL ARLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1) Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 27, MANNER OF DEATH 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO 8 2 Accident 28s. PLACE OF INJURY — At home, term, atreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 🐰 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(e) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(a) and manner as stated. 29h. SIGNAMURE AND TITLE OF CERTIFIER LICENSE NUMBER H 205/6 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9410 Ich dlman 32-REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



use as the burial-transit permit. Pages 1, 2, 3 should 10, page 5 should be detached notified at 9 must funeral director, examiner in by the fi medical filled the event, 1 burial, traumatic prior to OR ATTENDING PHYSICIAN: The law requires that the death certificate be other t any shows been s has be Dept. 23 certificate to the State this certification with the S 10 marked, DIRECTOR: After the hours after death v 40 28 Hem

DIRECTOR

FUNERAL

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CERTIFICATION

PHYSICIAN: MEDICAL

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TO THE HOSPITAL OF TO THE FUNERAL DE BE filed within 72 h

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATN 3. TIME OF DEATH October 13, Adele Lanehart 1995 8:15 A 7. DATE OF BIRTH (Month, Day, Year)

July 31,1904 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 - M 2 XX 214-14-7371 France 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Baltimore Meridian Heritage Nursing Ctr. Dundalk 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Dundalk Maryland Baltimore 1 YES 2 NO 100. STREET AND NUMBER 7232 German Hill Road 10g. CITIZEN OF WHAT COUNTRY? 21222 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 7 ANO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2X XNO Specify: 1 Never Married 2 Married 3 🖔 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Tavern Owner Tavern 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Sumame) Henrietta Darchicourt Ferdinand DuPont 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy C. Phillips 707 Meadow Avenue Dundalk, Maryland 21222 20e METHOD OF DISPOSITION

XX Burlel 2 Cremation 3 Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Louden Park Cemetery 4 Donation 5 Other (Specify) Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ahock, or heart fellure. List only one ceuse on each line. Onset and Death IMMEDIATE CAUSE (Finel disesse or condition MYDIANDAC /N FANCTION
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) Sequentially list conditiona, (OR AS A CONSEQUENCE OF) If any, leading to immediata cause. Enter UNDERLYING OPI CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 1 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
4 Untursing Home 5 Residence 6 Other (Specify) | | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?

1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 2 Accident 3 Suicida 28s. PLACE OF INJURY — At home, term, street, tectory, office NARSING HONE 4 Homicide 29a. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion,

AE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHATTER JEG 3927, AWNAPOUS

29c. LICENSE NUMBER

1)23530

29d. DATE SIGNED (Month, Day, Year)

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	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		NT OF HEALTH AND	MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (FIRST, MIN	N M. LOW	maN		2. DATE OF DEATH MONTH DA	1995			
	4. SOCIAL SECURITY NUMBER 214 52 952			DER 1 YEAR IF UNDER 24 HRS 8 DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Ybar) Oct. 8, 19	Cou	OTHPLACE (State or Foreign strity) SSachusetts		
TOR	90. FACILITY NAME (IT not Institute NORTH ARE RESIDENCE OF DECE	UNDEL HOSP	1 1	TY, TOWN DR LOCATION DF	DEATH 11C	ANNE	Alundel		
DIRECTOR	Maryland 10	Anne Arundel		ersville			10d. INSIDE CITY LIMITS? 1 YES 2 ND		
FUNERAL	100. STREET AND NUMBER	Angus Court		10f. ZIP CODE 21108		10g. CITIZEN DI	F WHAT COUNTRY?		
BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Me 3 Widowed 4 Divorce	12. WAS DECEDENT EVER IN FDRCES? 1 YES	2 XND	3. WAS DECENDENT OF HISF If yee, specify Cuben, Mex 1 YES 2 N NO Spe	Icen, Puerto Ricen, etc.)	BI	ACE — American Indian, ack, White, stc.		
COMPLETED		ENT'S EDUCATION Ighest grade completed) College (1-4 or 5+) 1 year	16e. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire	ne during most of working d.)	166. KIND OF BUS	SINESS/INDUSTRY			
E COM	17. FATHER'S NAME (First, Middl		Cahill		NAME (First, Middle, Meiden atherine Pas	Surneme)			
TO B	190. INFORMANT'S NAME (Type Ronald Low			ESS (Street end Number or Rur k Angus Cour			aryland 21108		
	20e. METHOD OF DISPOSITION 1 IX Burlel 2 Cremetion 4 Donation 5 Other (Sc 21. SIGNATURE OF FUNERAL S	3 Removal from State pecify) G	A:	emorial Park Emorial Park NAME AND ADDRESS DE George J. Go	10/14 Gle	Home P	e, Maryland .A.		
CERTIFICATION	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest. Approximate interval Between the mode of dying, auch as cardiac or reapiratory arrest.								
PHYSICIAN: MEDICAL CI	m	CONTRIBUTE TO CAUSE OF	ntunion	NO UNCERTA	PERFOR	PMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
TO BE COMPLETED BY PHYSICIA	EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Neturel 5 Pe 2 NA Accident Inv 3 Sulcide 6 Co 4 Homicide 6 CERTIF (Check only one) 296. CERTIFIER (Check only one)	IN Inpetient 2 ER/Output Prestigation 28e. DATE DF INJURY (Month, Day, Year) Creatigation 28e. PLACE OF INJURY building, etc. (Special Prestigation) 28e. PLACE OF INJURY building buil	286. TIME DF RNJURY At home, ferm, street, yy edge, death occurred at ti	Nursing Home 5 Resident 28c. INJURY AT WORK? 1 VES 2 ND factory, office	255 LOCATION (Direct City of Town, Stein) Sue to the cause(e) end ma	nner as attited, and due to the cour	ella		
2	UCTI 719	95 Java dwderk	TURE LANGE	Surre 2	1001 All	ary 1.	o Herry		

ITEM: 1. PER F.H. FILM G-728 10/27/95 t.t

	FOR STATE REGISTRAR	STATE OF MARYL					REALTH AND I	MENTA	REG. NO.	E				
-	1. DECEDENT'S NAME (First, Middle, Last) THERESA	ANN			KRIS			2. DATE MON OC	T. 13	, 19	95		ME OF DE	
	4. SOCIAL SECURITY NUMBER 215-78-5866	1₩ 2 X F	(In yrs. les	YRS.		DAYS	IF UNDER 24 HRS. HOURS MIN.	6 – 1	COF BIRTH (th, Day, Year) 2-63		8. BIRTI-	ny)	(State of	
TOR	99. FACILITY NAME (If not institution, give at ST. AGNES HO) RESIDENCE OF DECEDENT	,					MORE	ATH		9c. COU	NTY OF D	/ A	7	
DIRECTOR	100. STATE 10b. COUNTY	N/A			ALT								INSIDE CI LIMITS? YES 2	
FUNERAL	100. STREET AND NUMBER 111 S. LUZERNE	AVENUE				101	21224				ZEN OF V	WHAT (COUNTRY	7
BY	11. MARITAL STATUS t Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	RMED	16	yes, sp	CENDENT OF HISPAN Becify Cuban, Mexical 2 XNO Specify	n, Puerto		Spec	ACE — American Indian, Black, White, etc. Specify:		ndlan,		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 8 YEARS		(G life	CEDENT'S live kind of v Do NOT us	rork done di e retired.)	CUPATION TO THE CONTRACT OF T	ON ost of working	16	DWN					
BE CON	17. FATHER'S NAME (First, Middle, Lest) JAMES MATHIS 190. INFORMANT'S NAME (Type/Print)		1 40	- MAII MA	1000000	(0)	18. MOTHER'S NAI BONNIE	SQ	UIRES		0.43			
1	MS. BONNIE SQUI		4		. PA	TT	ERSON P	K.	AVE.		0.			1231
	t X Burlal 2 Cremation 3 Remu 4 Donation 5 Other (Specify) 2. SIGNATURE OF FUNERAL SERVICE LIC	oval from State		R'HI	her place)	CEM	ND ADDRESS OF FA	10	-18 A	. A.	СО			
_(23. PART I. Enter the disease, or o	Mondai	d the de	eth. Do n	25	525	OROWSKI FLEET	ST.	BALTI	0. M	D.	21:	224 Approx	imate
	shock, or heart fallure.	CARDIAC ARRY ACUTE HEPATI DUE TO (OR AS A	YTHMI ITIS,	A DUE And P	TO CHI	RONI	C RENAL FAI	ILURE	, AND				Interval	Batween and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A												
MEDICAL CER	PART II. Other elgnificant condition	d	but not	resulting	n the und	deriyin	g csuse given in	Part i.	24s. WAS AN PERFOR	MED?	248	COMI OF D	AUTOPS' ABLE PRIN PLETION D EATH?	OF CAUSE
AN: N	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C		TH YE				N 🗆				· yez	160 2	
PHYSICIAN:	EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Out		.,	OTHER 4 Nurs	: ing Hon	ne 5 🗆 Residence		ner (Specify)	N HIEV OC	CHRED			
ВУ	1 XX Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datermined	(Month, Day, Year) 28a. PLACE OF INJUR building, etc. (Spe	Y — At he	INJ	M	1 []	YES 2 NO	28t, LO	CATION (Street 4 y or Town, Stete)			Route 1	Number,	
COMPLETED		ICIAN: To the best of my know										a) and	manner a	a stated.
TO BE CO	29b. SIGNATURE AND TITLE-OF CERTIFIES	GEL	į				O.C.M.	MBER		29d, DAT	CT.	D (Mont	h, Day, Ye	ar)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

31. DATE FILED (Month, Day, Year)

OCT 1 7 1905

JE REGISTRAR'S SIGNATURE

111 Penn Street, Baltimore, Maryland 21201

3. TIME OF DEATH 0110 am

october 14, 1995

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Bryce

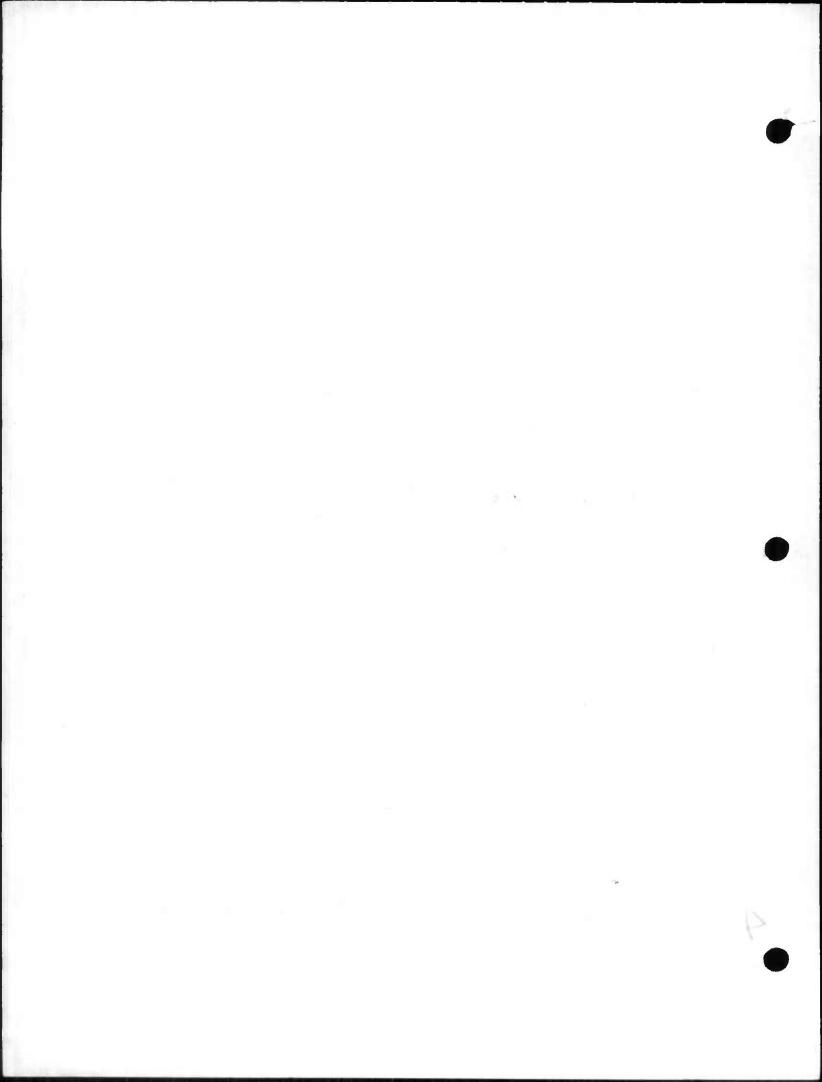
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9	ECTOR: After this certificate has been signed by the attending physician and completely filled	
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17AL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directo	
=	9	

_		215–15–900		5. SEX 1 M 2 □ F	6. AGE (In yrs. las		IF UNDER 1 Y	AYS	HOURS	MIN,	Dec	25,19	75	Country) Mary	ACE (State or Foreign
2. 3 should	TOR	90. FACILITY NAME (# not) I-70 east b	ound @				96. сіту, то Му		r locatio svil				9c. COUR	ederi	
burial-transit permit. Pages 1.	DIRECTOR	MD	10b. COUNT	Arundel		10c. CITY, Edg	TOWN OR L	OCATI	ION					- 1	d. INSIDE CITY LIMITS? XYES 2 \(\text{NO} \) NO
insit perm	FUNERAL	1508 Londo		Court					ZIP CODE 21037	,			10g. CITI		IT COUNTRY?
the burial-tra	ВҰ	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Div		FORCES?	IT EVER IN U.S. AF	RMED	If ye	s, spe	ENDENT OF clfy Cuban 2 NO	, Mexicar	n, Puarto F	7 (Specify Yea Nican, etc.)			
use as	ETED		CEDENT'S EDU		10	ECEDENT'S U	ork done duri	PATIO	N st of working	,	16b.	KIND OF BUS	SINESS/IND	USTRY	
og po	PLE	Elementary/Secondary	(0-12)	College (1-4 or 5	+)	ter.	retired.)					Restu	arant	t	
be detach	E COMPL	17. FATHER'S NAME (First, Robert Fra		lewis								Widdle, Maiden			
5 should notified	TO BE	19a. INFORMANT'S NAME Robert F.										oer, City or Tow dgewat			1037
ector, page must be		20a. METHOD OF DISPOSI 1 St Burlel 2 Cremet 4 Donation 5 Othe	lon 3 🗌 Rem	oval from State		AND DATE OF					10/1			City or Town	. State Le, MD
e funeral dir I. examiner		21. SIGNATURE OF FUNER	AL SERVICE LI	DENSEE	lit.	h	22. NAI	de an	D ADDRES	une	ral	Home, nnapol	P.A.	214	401
ending physician and completely filled I Hygiene prior to burial, cremation, or other traumatic event, the m	CERTIFICATION	shock, pr heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease Dr condition resulting in death) s. Multiple Traumatic Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury that initieted events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):													
has been signed by the att Dept. of Heatth and Menta 1 23 shows any Injury,	MEDICAL	PART II. Other signific									_	24s. WAS AN PERFOR	RMED?	Al Ci	ERE AUTOPSY FINDINGS ARLABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO
23 pept	ICIAN:	DID TOBACCO		RIBUTE TO CA		CE OF DEAT		-	UNC	ERTAIN	И 🗆				
tate tate	(C)	EXAMINER?		HOSPITAL:	☐ ER/Outpetient		OTHER:		e 5 🗆 Rac	sidenca	aX Othe	r (Specify)	Inter	cstate	2 70
ter this cen ath with the marked, o	ву РНУ	27. MANNER OF DEATH 1 Netural 5 2 X Accident	Pending Investigation	Oct 1	4,1995	28b. TIME INJU 0106	oa M	WO!	ES 2 (X	NO		senger			railer actor Coll
TECTOR: An after de m 28 is I	ETED	3 Suicide 8 4 Homicide	Could not be determined	l bullding	of injury — At he , atc. (Specify) rstate H			office	•		City	ATION (Street or Yown, State)	I - 70	E/B 4	+2 mile
THE FUNERAL DIRECTOR: After this certific fied within 72 hours after death with the S PORTANT: If Item 28 is marked, or I	COMPL	anal		ICIAN: To the best of											nd manner as stated.
TO THE FUNERA De filed within 7 IMPORTANT: 1	O BE	290. GUATURE AND TITL	mit	- I	1				D35		ABER				14, 1995
1		Andrew Zar	ick, J	r., M.D.	.P.O. I	36 36 36	9, Wa	lk	ersvi	ille	, Ma	ryland	2179	93-03	69
/		31. DATE FILOCT 1	71995	Folk &	H'S IGNAT	datt									
															DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

LEWIS

Robert



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-728 10/20/95 t.t Item1 10-17-95 FilmG728 W.H.Per F/H

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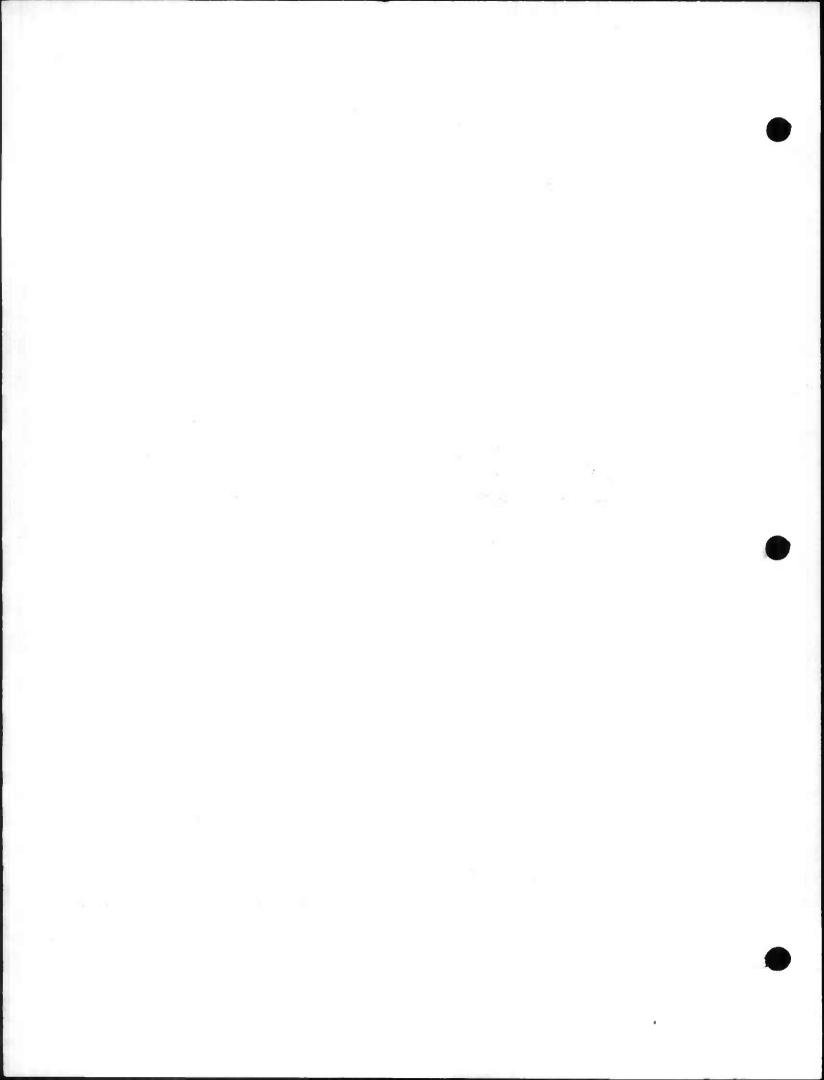
FOR

asp

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		- STATE REGISTRAR	CE			FDEATH		G. NO.		
)	1. DECEDENT'S NAME (First, Middle, Last) JAMES	LOCH	PAD			2. DATE OF DEA		YEAR 3.	TIME OF DEATH
	- 1	М.			Lock		OCT 0			10:27 AM
			6. AGE (In yrs. lest	VRS.	MONTHS DAYS		7. DATE OF BIRT	fear)	Country)	CE (State or Foreign
pino		9a. FACILITY NAME (If not institution, give street in	20		9b. CITY, TOW	OR LOCATION OF DE		2,1974	Mary Y OF DEAT	
. 2. 3 should	СТОВ	931 S. ELLWOOD				TIMORE C		N/		
ges 1.	EC	10e. STATE 10b. COUNTY		10c, CITY	, TOWN OR LOC	CATION			100	d. INSIDE CITY LIMITS?
7. Pa	DIRE	Md. N	I/A	Ва	1timore	2			15	YES 2 NO
perm	3AL	10e. STREET AND NUMBER				10f, ZIP CODE				T COUNTRY?
ransit	FUNER	3022 Dillon Street				21224		U.S		
one majorities or executions projections: detached for use as the burial-transit permit. Pages once.	BY FU	1XXNever Married 2 Married	WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES		If yes,	ECENDENT OF HISPAN specify Cubert, Mexicen ES 2 X NO Specify	n, Puerto Rican, e	rtc.)	Specify: India	
e as	ED	15. DECEDENT'S EDUCATION			USUAL OCCUPA		16b. KIND	OF BUSINESS/INDU		
for use	E			Do NOT us	vork done during : e retired.)	most of working				
detached once.	COMPL		I/A Lab	orer				as Corp.		
be detach	_	17. FATHER'S NAME (First, Middle, Last) James Edward Lock1	0.00			18. MOTHER'S NAI				
should b	BE	19a. INFORMANT'S NAME (Type/Print)		MAILINO	ADDRESS (Street	NOTINA INOTINA In and Number or Rural F	Iris Pe		inda)	
5 should notified	2	James E. Locklear				ill Dr.,Fa				06
page t		20s. METHOD OF DISPOSITION	20b. PLACE A	NDDATEC	F DISPOSITION			Oc. LOCATION — CI		
director, per must		4 Donation 6 Other (Specify)	Oak La	wn C	emetery	10/13/	95	Baltimor	e,Md.	
oeam. Pag tuneral dii I. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENS	" 113 1	-	22. NAME	AND ADDRESS OF FA	CILITY	2	1224	
exar		· mondo	X bull		Lilly	& Zeiler	Inc. 7	00 S.Con	kling	Street
hours after death. Page 6 may be retained by ed in by the funeral director, page 5 should be or removal. medical examiner must be notified at		23. PART I. Enter the diseases, or company shock, or heart fellure. List	plications that caused the deconly one cause on each line.		ot enter the r	node of dying, suci	h aa cardiec o	respiratory arres	it,	Approximate interval Batween
y filled in tion. or the me		IMMEDIATE CAUSE (Finel	only one codes on each line.							Onset and Death
		disease or condition resulting in death) s	NARCOTIC INTOXIC							
executed within and completely o burial, cremati matic event, t			DUE TO (OR AS A CONSEC	DUENCE OF	7):					
and and	RTIFICATION	Sequentially list conditions, if sny, lesding to immediate	DUE TO (OR AS A CONSEC	UENCE OF	F):					
that the death certificate be of by the attending physiciar in and Mental Hygiene prior iny injury, or other trau	CAT	cause. Enter UNDERLYING CAUSE (Disease pr injury								
ing phy giene p	F	that initiated events	DUE TO (OR AS A CONSEC	UENCE OF	7):					
peam ceruncate be a attending physician mal Hygiene prior to y, or other traun	EI	resulting in death) LAST								
ned by the attential any injury, o	AL C	PART II. Other significent conditions co	ontributing to deeth but not re	eeuiting i	n the underly	ing cause given in		NAS AN AUTOPSY PERFORMED?		RE AUTOPSY FINDINGS
	2							YES 2 NO	CO	AILABLE PRIOR TO HIPLETION OF CAUSE DEATH?
w requires been sign pt. of Healt 3 shows	MEDICAL									YES 2 NO
has beer Dept. of		DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DEA	TH YE	S NO	☐ UNCERTAIN	1 🗆			
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	E OF DEAT	OTHER:					
certificate the State the State the State	YSI	1 🖾 YES 2 🗍 NO	Inpetient 2 ER/Outpatient 3		4 - Nursing H	ome 5 X Residence				
her this ce teath with t marked,	PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	FOUN	URYA I	NJURY AT WORK?	UNKNOWN	HOW INJURY OCCU	RED	
After death death	ВУ	2 Accident Investigation 3 Suicide SYY Could not be	FOUND ON 10/9/95 289. PLACE OF INJURY — At hor		. 0 11	YES 2 X X NO		(Street and Number o	r Rurai Rout	e Number
OR ALTENDING DIRECTOR: After hours after death tem 28 is ma	9	3 Suicide 8 XX Could not be determined	building, atc. (Specify)	ND AT			City or Town	(Street and Number of State) 931 S.	ELLW	OOD STREET
OR A DIREC hours	E	29e. CERTIFIER 1 CERTIFYING PHYSICIAN	I: To the best of my knowledge, de	-		ate end place, and due				
	OMPL	(orroon only	n the besis of examination end/or i							nd menner as stated.
FUN WITH	E CC	29b. SIGNATURE AND TITLE OF CERTIFIER	101111			29c. LICENSE NUI	MBER	29d. DATE	SIGNED (M	onth, Day, Year)
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	Ω		41 24			O.C.M	.E			,1995
	10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITEM	1 27) (Type,	Penn !	Street,	Baltim	ore, Ma	ryla	and 21201
H		OT. DATE FILED (Month, Day, Year)	32 REGISTRAR'S DENATURE							
	- 1	OOIT (IJJB // "								

OHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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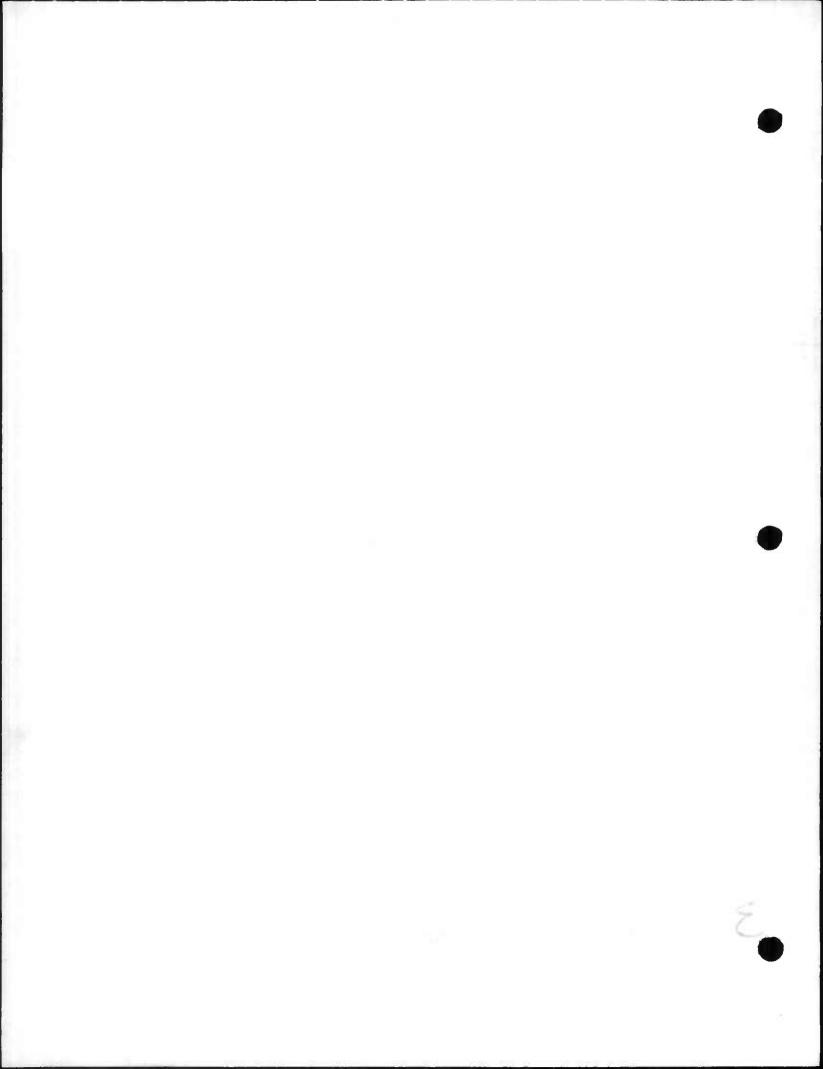
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE C	F DEATH		THOS.	3. TIME OF DEATH	
	I	BESSIE	L.	L	ERNE	2				OCTO	BER 1	Ĩ,199	95	12:15pm w	
1	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		-	R 24 HRS.	7. DATE O	F BIRTH			IPLACE (State or Foreign	
	212-56-4544	1	1 🗌 M 2 🔀 F	94	YRS.	MONTHS	HONTHS DAYS HOURS MIN. (Month, Day, Year) SEPT. 15,190					1901	Ol RUSSIA		
Ī	9a. FACILITY NAME (If not in			9b. CITY	, TOWN	OR LOCAT	ION OF DE				NTY OF D				
DIRECTOR	NORTHWEST I		AL CENTER	₹		RANDALLSTOWN B						BALTI	MORE		
EC	10e. STATE	10b. COUHTY			10c. CIT	Y, TOWN (OR LOCA	TION						10d. IHSIDE CITY	
11	MARYLAND		I/A			E	BALT	IMOR	E					LIMITS?	
FUNERAL	4168 CRESTI	HEIGHTS	ROAD				10	of, ZIP COL				10g. CIT		WHAT COUHTRY?	
¥ I	11. MARITAL STATUS		12 WAS DECEDED	IT EVER IN U.S. AF	MED	12	WAS OF		215	uc opicini	(Specify Ye		USA	E — American Indian,	
	1 Never Married 2	Married	FORCES?	YES 2 XI	NO		It yes, s	pecify Cub	en, Mexica	in, Puerto Ri	can, etc.)	of No-	Blac	k, White, atc.	
BY	3 X Widowed 4 □ Dive	orced	IF YES, GIVE Y	MAR OH DATES			1 L YE	S 2 [XNC) Specify	у:			Spec	WHITE	
COMPLETED	15. DEC (Specify on	EDENT'S EDU	CATION completed)	16a. DE	CEDENT'S	USUAL O	CCUPAT	ION	rina	16b.	KIND OF BU	SINESS/IH	DUSTRY		
91	Elementary/Secondary (T	College (1-4 or 5	life	. Do NOT u	se retired.)									
MP	8				HOMEN	IAKER	}					OWN	1 HOW	íE	
E CO	17. FATHER'S NAME (First, A GEORGE	fiddle, Last)	C	CHAMISH					THER'S HA	ME (First, M	GOLD		CORN'S	nishkoff	
0	19a. INFORMANT'S HAME (Type/Print)		19	b. MAILING	ADDRES	S (Street	and Numb	er or Rurat	Route Numbe	er, City or Tow	vn, State, Zi	p Code)		
2	MR. BERNARI		LERNER		12 ST	TRAW	HAT	RD,	APT.	. 1-B	OWING	GS MI	LLS.	MD 21117	
	20a. METHOD OF DISPOSIT	IOH on 3 🗆 Rem	oval from State	20b. PLACE	AND DATE	OF DISPOS	SITION (A	lame of		DATE	20c. LC	CATION -	City or To	own, State	
	4 Donation 8 Other	r (Specify)	. 1/	cemetery H	EBREV			_			-1 995	BALI	IMOF	E, MD	
	21. SIGNATURE OF JUNERA	SERVICECK	XXXXX				100	10-11-11	ESS OF FA						
	WUCH	WV-	Duly	en		10	010	DET	ampo	TOTAL T	DS.,	-		03035	
	23. PART I. Enter the dahock, or himmediate CAUSE (Fi disease or condition resulting in death)		List only one ca	et couned the de use on aach ilne	eath. Do	not enter	the m	ode of d	O. A	ch aa card	ac or reap	iratory e	reat,	Approximate interval Between Onset and Death	
	Total in oddin,		DUE TO	(OR AS A CONSE	OUENCE O	F):		0	- 1	(1	scul	7			
S O	Sequantially list condit	tiona,	b. OUE TO	OF AS A COHSE	alu	ial	~	Con	to	Va	scul	2 1/4	in	\$	
CERTIFICATION	if any, leading to imme cause. Enter UNDERLY		00210	(OR AS A CONSE	OUENCE U	r-):									
띮	CAUSE (Disease or Injuthat initiated events	ury	DUE TO	(OR AS A COHSE	OUENCE O	F):		-							
F	resulting in death) LAS	ST	d												
	PART II. Other algolification	ant condition	a contributing to	death but not	outline	Im Albania			alessa la	Deat I				WERE AUTOPSY FINDINGS	
MEDICAL	PART II. Othar alignmen	ent condition	e contributing to	oaath but not	readiting	in the ur	nderiyii	ng cause	given in	Part I.	24s. WAS AN PERFO		248	AMILABLE PRIOR TO COMPLETION OF CAUSE	
<u> </u>										-	1 TYES	NO NO		OF DEATH?	
_	DID TOBACCO U	ISE CONIT	DIRLITE TO CA	VIICE OF DEA	TLI V	EC []	NO F	7 LIN	CEDTAI	NI D				1 TES 2 (NO	
AN	25. WAS CASE REFERRED		KIDUIL IO CA		CE OF DEA				CERIAI						
	EXAMIHER?		HOSPITAL:	© ER/Outpatient		OTHE	R:		Di afdi a	4 [] Oit :	4D				
PHYSICIAN:	27. MANHER OF DEATH		28a. DATE O	FIHJURY	28b. TIN	IE OF	_	JURY AT	Residenca	6 Other	(Specify)	IHJURY O	CURED		
ВУ Р	1 Heturni 5 2 Accident	Pending Investigation		Day, Year)		JURY M	W	ORK? YES 2	□ но						
COMPLETED	3 Suicide 6 4 Homicide	Could not be determined	28e. PLACE (building	OF IHJURY — At he, atc. (Specify)	ome, term,	street, lac	tory, offi	ca		261. LOCA City o	TION (Street Town, State	and Number	er or Rural	Route Number,	
片	29a. CERTIFIER (Check only	TIFYING PHYS	CIAH: To the best o	f my knowledge, de	eath occur	red at the t	time, dat	a and plac	e, and due	to the caus	e(e) end me	nner ea at	rted.		
OM	anal .													a) and menner as stated.	
띪	296. SIGNATURE AND TITLE	E OF CERTIFIE	on &	ter l.	-0-2	2		29c. Lft	CEHSE HUI	MBER R 9 to		29d. DA	TE SIGNED	(Manth, Day, Year)	
5	30. HAME AND ADDRESS O		o completed cal				DS I	DRIVE	E OWIT	2) / 0	TI.I.S	MD	2111	7	
	31. DATE FILED (Month, Day,			AR'S SIGNATURE	0.100	J. (OA)	JJ 1	AT AT	. 0111	-400 F		עוניו	C441	•	
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DIVISION	

		1 - FOR STATE OF MARYLAND / DEPARTMENT / DE		IENTAL HYGIENE REG. NO.	E	
		1. DECROENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	3	. TIME OF DEATH
	1	ZARL C. Mills		LO LZ	Q YEAR	0410
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) F UNDER 1 Y		7. DATE OF BIRTH	8. SIRTHPL	ACE (State or Foreign
2		212-46-6776 1× M 2 - F 46 YRS. MONTHS D.	AYS HOURS MIN.	(Month, Day, Year) 2-25-	49 Bac	Himore
pinous	_		OWN OR LOCATION OF DEAT	ATH O /	Sc. COUNTY OF DEA	TH /
1. 2. 3	DIRECTOR	MINURSITY HOSPITAL BA	Utimore	City	Baltim	rune City
Pages	DIRE	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR L	nure CI	1+11	10	Od. INSIDE CITY LIMITS?
permit.		10s. STREET AND NUMBER	101. ZIP CODE	1	10g. CITIZEN OF WHA	YES 2 NO
	ERAL	927 N. Mount Street	2/2/	7	U.S	
020 physician. burial-transit	FUN	11. MARITAL STATUS	DECENDENT OF HISPANIC			- American Indian,
-0020 ling physic the burial		1 Never Married 2 Married FORCES? 1 YES 2 NO If ye	es, specify Cuben, Maxican, YES 2 NO Specify:	Puerto Rican, atc.)	Black, V	White, stc.
	ВУ	3 Wildowed 4 Divorced	TES 2 % NO Specify.		Specify:	Black
r attenduse as	윤	15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCU (Specify only highest grade completed) (Give kind of work done during the completed)	PATION	16b. KINO OF BUSI		,,,
0 %	Ē	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)	ny most or working		1 -	,
AND the hospital detached for once.	₽ N	124h TRUCK	DRIVER	TRACT	tor IRa	ilere
e de ta	COMPL	17. FATHER'S NAME (First, Middle, Last)	16. MOTHER'S NAME	E (First, Middle, Maiden S	iumame)	
A pe	BE	Raymond Mills	Emma	2 B. 5	someey	/
4 5 5 E	0	19a. INFORMANT'S NAME (Nype/Print) 19b. MAILINO ADDRESS (ST	treet and Number or Rural Roo	ute Number, City or Town,	, State, Zip Code)	
E, M y be ret sage 5 s	-	Earl A. 111,1113 427 N.11	Yount St.	Baltino	IRE, MD	2/2/1
		20a. METHOD OF DISPOSITION Burlei 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITIO	N (Name of	DATE 20c. LOC	ATION — City or Town	, State
a et e		Surial 2 Cremetton 3 Removal from State cametery, crematory or other place) Other (Specify) T, Z'ON (emetery 1	0-18-95 B	Baltimore	2 County
ALTIM death. Page tuneral dire .		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	AE AND AODRESS OF FACH	VITY AL SO SI	Tunesal	thone !
death. F tuneral		Jun P. Cassoll	1000 - 6	reh ?	unce	rione
after after Dy the moval		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the	mode of dying such	as cardiac or menin	nuc	I Approving at a
hours after the transport or removement of the transport		anock, or haart failure. List only one cause on each line.	/ mode of dying, seci (as carolac or respire	nory arrest,	Approximata Interval Batween
the the	1 1	iMMEDIATE CAUSE (Finel disease or condition	ALACLI	1.75		Onset and Death
ompletel ompletel al. crema		resulting in death)	A7007 F	110		ļ
c ev	-	= S A Stage	Courses	D7		İ
exect and to but mati	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate		<i>y</i> <u> </u>		
Siciar prior	M	cause. Enter UNDERLYING	ever to	106 /		İ
Tifical tifical phy ene	Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):				+
Hygi	F	resulting in death) LAST				
the deat the atte the atte d Mental	O					
	Ä	PART II. Other significant conditions contributing to death but not resulting in the under	iying cause given in Pa	art I. 24s. WAS AN A PERFORM		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
requires that the een signed by the of Health and shows any in	MEDICA			_ 1 U YES 2	J NO CO	OMPLETION OF CAUSE F DEATH?
requires sign of Heal	Æ			_ '	'	YES 2 NO
AL ME e faw requents been Dept. of 23 sho	ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	UNCERTAIN	40		
N: The fav ficate has State Dep	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER	one)			
Certificate the State	YSI	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing	Home 5 🗆 Rasidence 6	Other (Specify)		
PHYSICIAN: The faw this certificate has b with the State Dept.	PHY	(Month, Day, Year) INJURY	: INJURY AT 2 WORK?	28d. DESCRIBE HOW IN.	JURY OCCUREO	
DING PHYS After this death with	B	2 Accident Investigation	YES 2 NO			
ATTENDING ECTOR: After s after death	ED	3 Suicide 6 Could not be delarmined 28s. PLACE OF INJURY — At home, farm, atreet, factory, building, atc. (Specify)	office 2	28f. LOCATION (Street and City or Town, State)	d Number or Rural Route	le Number,
OR ATTENDING DIRECTOR: After nours after death	<u> </u>					
AL OR A L DIRECT POURS	P	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime,	data and place, and due lo	The cause(a) and menn	er se stated.	
HOSPITAL FUNERAL Within 72 I	COMPL	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion				nd manner as stated.
THE HOSPI THE FUNER filed within		ZHI, DIGHATURE AND TITLE OF DERTIFIER	29c. LICENSE NUMBE		29d. DATE SIGNED (Mc	
THE THE DE FIED FIED FIED FIED FIED FIED FIED	BE	Kodoubly Ap Mostor Fol Non-	D472		D 10/17	195
F F A	2	18. NAME AND ADDRESS OF PERSON WHI COMPLETED CAUSE OF GEATH (ITEM 27) (Typo, Print)			7.0	1.0
a		DevJAMIN Duffey, M)				



MORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

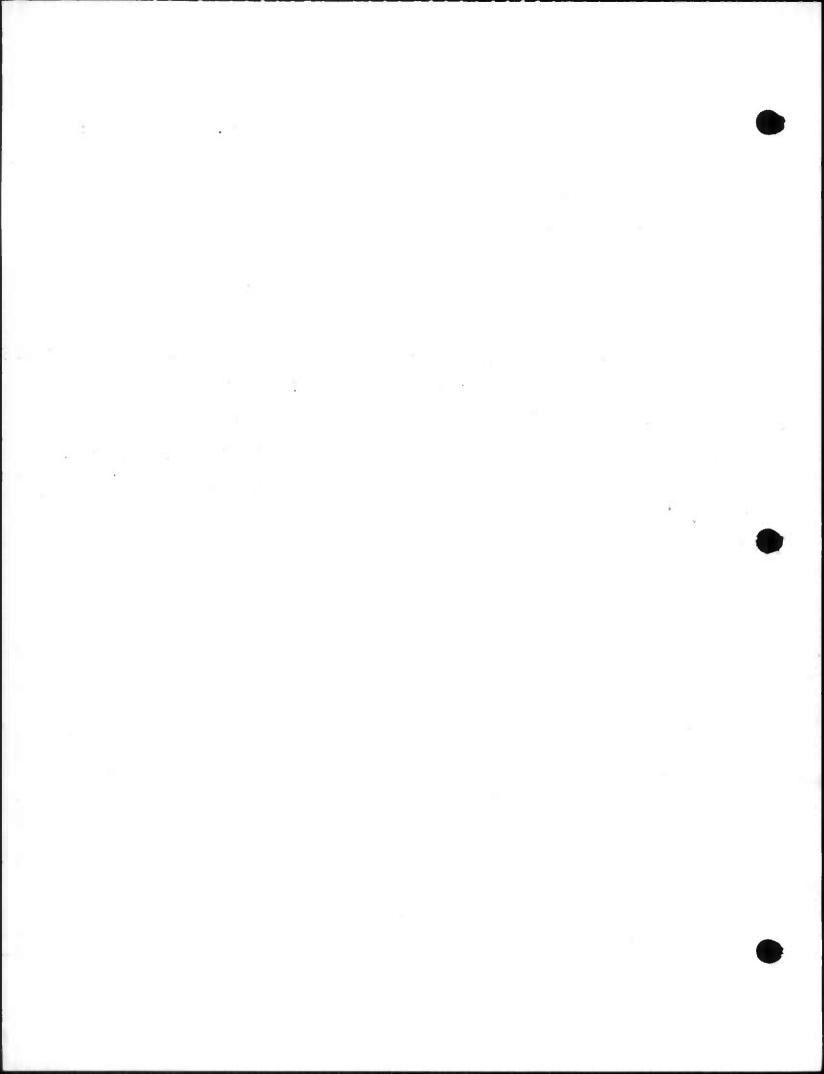
TO THE HIGHAL DRECEDS. After this certificate has been supped by the attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burish-transit permit. Pages 1, 2, 3 should be filled with the State Dept. of Health and Merital Hygiens prior to burish, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First,	Admirán Landi			<i></i>	IOAIL	<u> </u>	DEAIII	Tan	ATE OF DEATH		_	
MSGR. F	1	Joseph		anns					DNTH D	4 1	995	2:15 F
SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	lear birthday)	IF UNDER 1	TEAR	IF UNDER 24 HR	B. 7. DA	NTE OF BIRTH forth, Day, 'Mar)		A. BURT	HPLACE (State or Foreign
220-44-2281		1 X M 2 F	92	YRS.	SOURT HE	DAYE	HOURS MIN		rch 25,	1903		rvland
FACILITY NAME (If not in	ettlution, give i	(vedmun bos seens			9b. CITY,	TOWN	OR LOCATION OF			Spinister, Spinister,	NTY OF	DEATH
Stella Ma	ris H	ospice			Т	OWS	on			Ba	ltim	are
w. STATE	10b. COUNT			10c. CITY	Y, TOWN OF	LOCA	TION				-	10d. INSIDE CITY
Maryland	Bal	timore		7	I'owso	n						LIMITS?
e. STREET AND NUMBER							E. ZIP CODE			10g, CIT	TZEN OF	WHAT COUNTRY?
2300 I	ulane	v Vallev	Road				21204			17	.S.A	
MARITAL STATUS	501.70-77	12. WAS DECEDEN	T EVER IN U.S.		13. W	MS DEC	CENDENT OF HIS	PANIC OR	IGIN7 (Specify Yes		14. RAC	E - American Indian.
Never Married 2 Widowell 4 Divor			WAR OR DATES	X			ecity Cution, Me 3 2 XHO Sp		rto Rican, etc.)		Spec	White
	DENT'S EDU		16a.	DECEDENT'S	USUAL OCC	CUPATI	ON and and and a second a second and cond and a second and a second and a second and a second an		16b, KIND OF BUI	SINESS/INC	DUSTRY	71111100
Elementary/Secondary (0-		College (1-4 or 5	+1	(Give kind of w We Do NOT us		and a	and or working					
		8 yrs.		Priest	t				Religi	on R	oman	Catholic
FATHER'S NAME (First, MI	THE PARTY OF	NATION AND ADDRESS OF THE PARTY.	DE 000 - 111				CONTRACTOR OF THE PARTY OF THE		st, Middle, Meiden	Sumame)		
Frederic	-	B. 1	Manns				Clara	1	M. F	orem	an	
. INFORMANT'S NAME (7)				19b, MAJLING	ADDRESS	(Street i	and Number or Ru	mil Route N	lumber, City or Ree	n, Sten, Zi	Gode/	1
James C. Gr	eenwe	11		616 I	orse	y R	load I	el A	ir, Mar	ylan	d 21	014
METHOD OF DISPOSITI		and too Free		E AND DATE O		non/n	unse of		ATE 201. 1,0	CATION	City or To	rwn, State
Donation 5 C Other		novel from State	Mantar .	Cathe		Com	etery 1	0/17	/05 Ral	timo	ro i	Maryland
MEDIATE CAUSE (Fin. sease or condition suiting in death) quentially list condition supply, leading to immeduse. Enter UNDERLYII USE (Disease or Injuret initiated events	ons, flate	n Renal pue to	OR AS A CONS	EQUENCE OF	3							Onset and De
sulting in death) LAST	•	d.	death but not	t ensulting i	n the und	la et ele		to Best I	. 24s. WAS AN	a communication	L	
				. resuming i	n and and	- Trynn	y cause given	M. PHELI	PERFOR	MED?	240	MERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO US	SE CONT	RIBUTE TO CA	USE OF DE	ATH YE	S D N	08	UNCERT	AIN 🗆				
WAS CASE REFERRED TO EXAMINERY				ACE OF DEAT		_	-		-			
1 YES 2 NO		HOSPITAL:	ER/Outpettent	3 [] DOA	OTHER:	ng Hom	e 5 🗆 Residen	e 6 🗆 o	ther (Specify)			
MANNER OF DEATH	ending	28s. DATE OF (Moreh, D	(NJURY (m) (m)	280. TIME INJU	OF 2	He INJ	URY AT	-	DESCRIBE HOW II	NJURY OC	CURED	
2 Accident In	ould not be	28s. PLACE O	FINJURY - AL	home, farm, e	treet, factor		YES 2 NO	386.6	OCATION (Styles a	and Number	or Aurel I	Route Mumber
	stermined	ounding,	etc. (Specify)						Oty or Town, State)			
		ICIAN: To the best of										i) and manner as stated
SIGNATURE AND TITLE				- Contracting to lot	- es es es es es es	matty (0	290 TACENSE		and place, an	29d. DAT	E BIGNED	(Month, Day, Year)
NAME AND ADDRESS OF	DEDECH WIT	O COMPLETED STATE	OF DE CO.	F10. 0.0			/					6
			entropolis Estrato	Contract of the Contract of th	0.000							
Eddie Nakhuda			ney Valle	ey Road	, Tows	m,	MD 2120	И				
OCT 1 7199	15	As 3	US SIGNATURE					<i>i</i>	1			
. 100	· // /											



BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital or attending physician. The furneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ral.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	FOR 1 - STATE REGISTRAR	STATE OF M	ARYLAN			HEALTH AND	MENTAL HYGIEN					
i	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH		YEAR	3. TIME OF DEATN		
	WILLIAM RO	obert		MAXW	ELL Jr	•	OCTOBER 12	MONTH DAY		23:05		
	4. SOCIAL SECURITY NUMBER		6. AGE (In y	rs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign		
	255-07-9817	1XXM 2 □ F	75 YRS. MONTHS DAYS HOURS MIN. July 3, 1			920 Georgia						
5	90. FACILITY NAME (If not institution, give s CALVERT MEMORIAL HOS		PRINCE	DEATH	CAL /EXT							
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY T					ATION						
DIMECTOR	Maryland Garrett				Mountain Lake Park					10d. INSIDE CITY LIMITS? 12 YES 2 NO		
LOINEDAL	2032 Maryland Highway					21550	U.S.A.					
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3. Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 V IVES 2 IF YES, GIVE WAR OR DATES WW2				ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yellow) 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yellow) 16. YES 2 1/2 NO Specify:					se or No— 14. RACE — American Indian, Black, White, etc. Specify: White		
3	15. DECEDENT'S EDU	CATION	16	a. DECEDENT'S	USUAL OCCUPA	TION	16b, KIND OF BU	SINESS/IND				
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(GIVe kind of work done during most of working									
	Grade 12			Engineer Railroad								
COMPLEIED	17. FATHER'S NAME (First, Middle, Last) William Robert Maxwell						AME (First, Middle, Maiden	Sumame)				
		27.11.011					Christian					
2	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or Tox					
	William R. Maxwel	LI III	_			l H i ghway						
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ramovel from State 4 Donation 6 Other (Specify) DATE 10/14 Catonsville, Md.											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A.											
	313 Talbott Avenue Laurel,						Ма	20707				
NOTION IN	23. PART I. Entar the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
	resulting in death) LAST											
	BADT II Obbes destillated and distance with the											
	molsable (or pulmoncelor 1 yes 2 kmo							WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN &											
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
	1 YES 2 KNO 27. MANNER OF DEATH	1 Nopetient 2 1			4 - Nursing No		6 Other (Specify)					
	1 Netural 5 Pending	5 Pending (Month, Day, Year) INJURY WORK?										
	2 Accident any series of the s							Noute Number,				
	4 Nomicide detarmined City or Town, State)											
	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piecs, and due to the cause(s) and menner as stated.											
· -	296. SIGNATURE AND THE OF CERTIFIE		1			-						
	29C. LICENSE NUMBER 29C. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)											
1	30. NAME AND APPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)											
	30. NAME AND APDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print). J. Flears, 120 (task) talk Rd., Pr. Fredenide, MD 20678											
	OCT 1995 Jahr William Strakes Gonzule											

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR

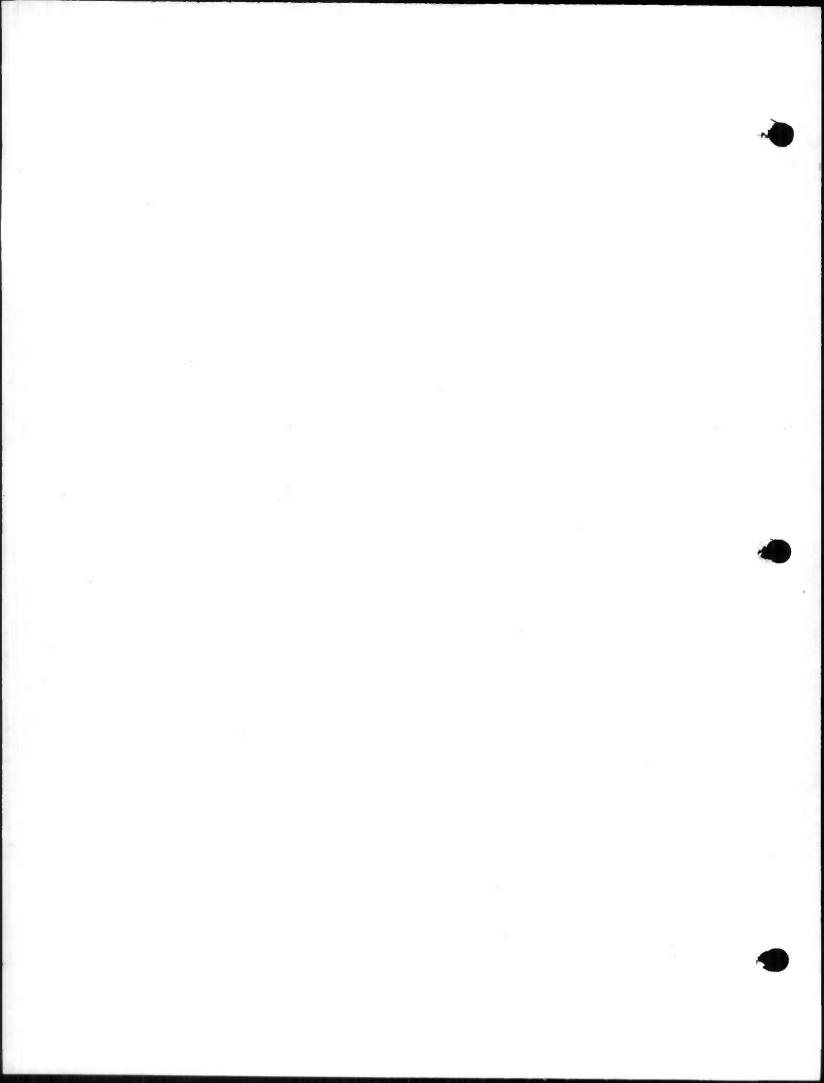
CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

LIANNITE

C. MCMILLION CD. OCT. 1.1

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF OEATH MONTH DAY YEAR 3. TIME OF DEATH													
	WANNIE					MCMILLION. SR				OCT. 11st 19			5 09:50 AMM	
	4. SOCIAL SECURITY NUMBER		. SEX		IE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS HOURS MIN. (Month, Day, Year)				BIRTHPLACE (State or Foreign Country)					
	236 07 378	3	№ M 2 🗆 F	76	YRS.					1 3,	1919		st Virginia_	
~	9a. FACILITY NAME (If not ins	titution, give stree	t and number)			9b, CITY	, TOWN C	R LOCATION OF O	EATH		9c. COU	NTY OF D	PEATH	
DIRECTOR	NORTH ARUN	VDEL HO	SPITAL	ASSOCT	TION	G	LEN	BURNIE			L A	Α.	COUNTY	
EC	10s. STATE 10b. COUNTY				10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY	
F	Maryland	Anne	Arunde	1	Ri	vier	a Be	each					1 TES 2 NO	
AL	10e. STREET AND NUMBER					10f. ZIP CODE				10g. CITIZEN OF WHAT				
<u> </u>	161 Meadow Road					21122					U	J.S.A		
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 X									an, Puerto Rican, etc.) Black, White, e			E — American Indian, k, Whita, etc.	
B	3 X Widowed 4 Divorced					1 Nes 2 No Specify:						Specify: White		
	15. DECE	DENT'S EDUCAT	TION	18a.	DECEDENT'S	EDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY							WIIIOC	
COMPLETED	(Specify only Elementary/Secondary (0-	highest grade co.	mpleted) College (1-4 or 5	+)	(Give kind of a life. Do NOT us	work done se retired.)	during mo	st of working						
립	8th				Motorman					Chemi	cal C	ompa	iny	
Ö	17. FATHER'S NAME (First, Mil					18. MOTHER'S								
BE (Wı	lliam M	CMillio					rena	Dani				
10	19a. INFORMANT'S NAME (7)							and Number or Rural					3 01100	
	Joyce Howa				215 G							_	d 21122	
	20a. METHOD OF DISPOSITION 1 → Burial 2 □ Cremation	n 3 🗆 Ramovi	al from Stata		E AND DATE				DATE			ATION — City or Town, State n Burnie, Maryland		
	4 Donation 5 Other		ISEF	_ Grei	nave					3 61	en Bu	irnie	e, Maryland	
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.												
	Klonn	1/4	mas	nerse	whi	_						_	d. 21225	
	23. PART i. Enter the di shock, or he		only one car			not enter	r the mo	ide of dying, su	ch as care	liac or rea	piratory ar	rreat,	Approximata Interval Batween	
								Onset and Death						
	resulting in death)	SEOUENCE O								(aday)				
		_	Fin		fin a	r).							5 years	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate Due 70 (or as a consequence of):													
CAT	cause. Enter UNDERLYING Oal Winer 1													
E	that initiated events resulting in death) LAST Congression Congressi								21/10/					
ER	resulting in destri) LAS	d.	//(ut-1		1 41101	1				7411)			
	PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
MEDICAL	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?													
E	1 YES 2 NO OF DEATH?													
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
SIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)													
PH	27. MANNER OF DEATH		26e. DATE O (Month,	F INJURY Day, Year)	28b. Till IN	28b. TIME OF 28c. INJURY AT WORK?			28d. DESCRIBE HOW INJURY OCCURED					
В	1 Netural 5 Pending 2 Accident Investigation					М		YES 2 NO						
ED	3 Suicide 6 Could not be 4 Homicide datermined					street, fac	ctory, offic	ca .	26t, LOCATION (Street and Number or Rural Route Number, City or Yown, State)				Houte Number,	
ET														
COMPLET	29s. CERTIFIER (Check only one) The Death of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as attack.													
S	2 MEDICAL EXAMINER: On the basis of axisministion and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and manner as sected.													
ш	29b. SIGNATURE AND TATKE OF CERTIFIER					29c. LICENSE NI						D (Month, Day, Year)		
TO B	SO, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								2/83					
_				octil dilino			_	uees t==		N of the same			0106	
	FILIOTT GORBATY, M.D./7845 OAKWOOD ROAD, #203/GLEN BURNIE, MARYLAND 21061													
	OCT 1 71995 July Student Collett													
	441410	0	- Lawren		70								DHMH-16 Rev 1/8	



BALTIMORE, MARYLAND 21215-0020

Let hours after death, Page 6 may be retained by the hospital or attending physician.

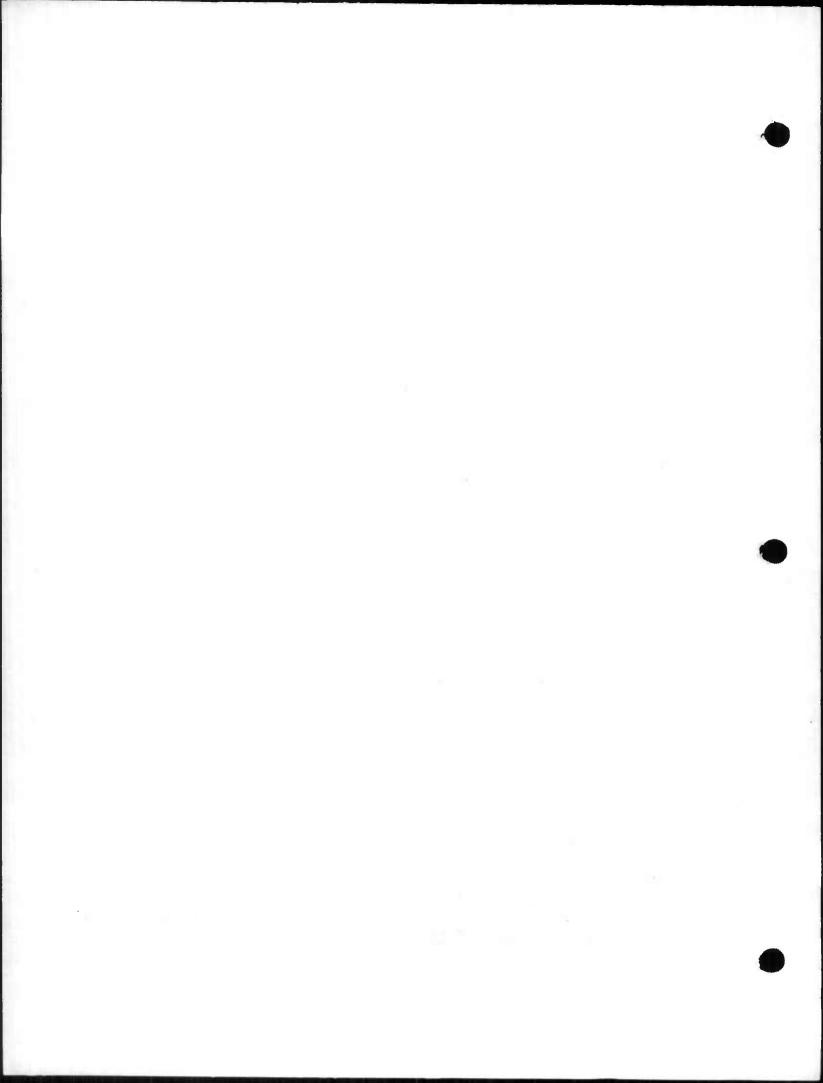
By the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a few after feath. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygnene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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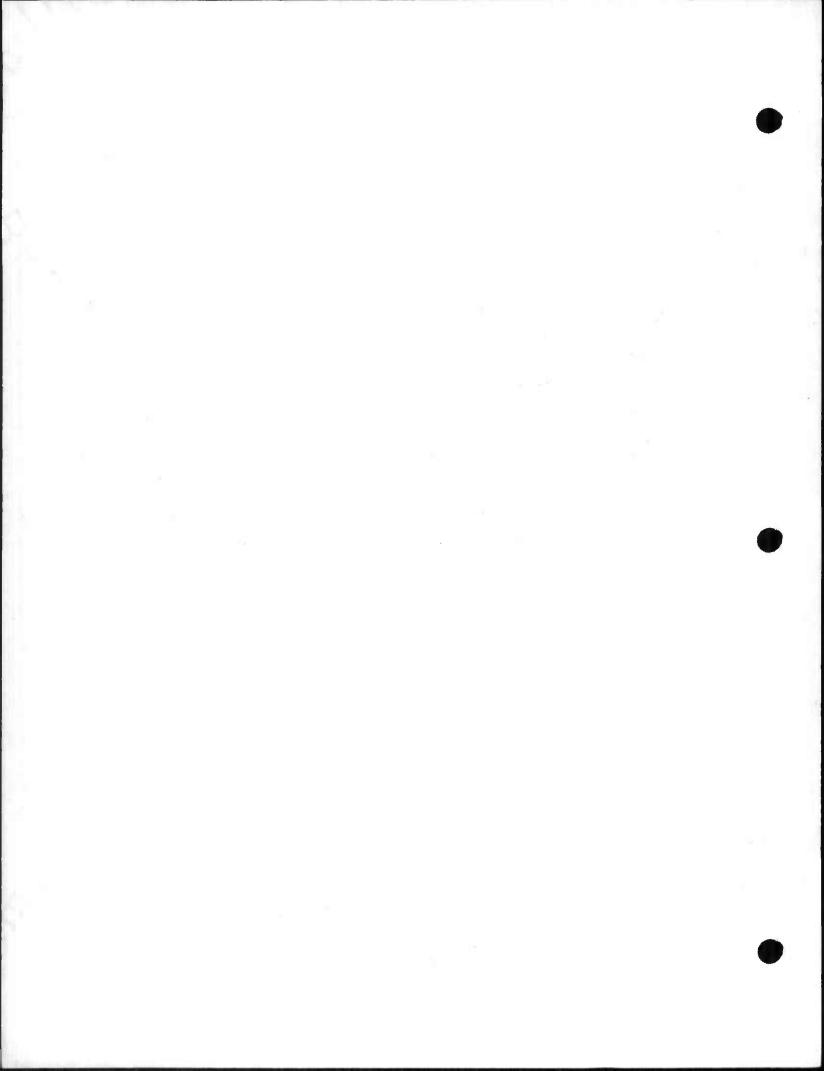
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	* REGISTRAR		CERTIFI	CATE	OF DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH OCTOBER 14,1995 YEAR 09:02 A									
DIRECTOR		Mewshaw								
			in yrs last birthday) O YRS.	MONTHS DA		7. DATE OF BIRTH (Month, Day, Year) August 19		BIRTHPLACE (State or Foreign Country) Marvland		
	9a. FACILITY NAME (if not institution, give stre		9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH				
	The Johns Hopkin	s Hospital	Balt	imore Cit	у	N/A				
JE C	10a. STATE 10b. COUNTY	10d. INSIDE CITY LIMITS?								
	Maryland Ann	e Arundel	Li	inthicum			1 VES 2 NO			
FUNERAL	405 Kingwood Ro	ad		21090			S.A.			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)			or No- 14.	RACE American Indian, Black, White, atc.		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 🗆	Specify: White					
0	15. DECEDENT'S EDUC		18a. DECEDENT'S		PATION g most of working	TRY				
	Elementary/Secondary (0-12) College (1-4 or 5+)			e retired.)	y most or working					
COMPLETED	8th	Home M	laker		Own H					
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden				
BE	19a, INFORMANT'S NAME (Type/Print)	ussell P. Li			Ida	a M. Dav Route Number, City or Tow				
2	Patricia A. Mar	+in				Linthicum,				
	20s. METHOD OF DISPOSITION		PLACE AND DATE			7		or Town, State		
	1 Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State	netery cremetony or o	thar nlanal	,					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
	George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225									
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	shock, or heart fallure. List only one cause on each line.									
	disease or condition my ocardial interchory									
	resulting in death) a. Due to (or as a consequence of)									
Z	IMMEDIATE CAUSE (Finel disease or condition resulting in death) B. My O Card IN INTERCTION B. DUE TO (OR AS A CONSEQUENCE OF) CO MANY AT LOS ASSECUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	oue to (or as a consequence of): If any, leading to immediate couse. Enter UNDERLYING									
FIC	CAUSE (Disease or Injury C. Due to a consequence of									
E	resulting in death) LAST	that infinited eventa								
	d									
EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO									
00	MM12 05 STructse 34/m may disunse 1 yes 2 10 GOMPLETION OF CAUSE OF DEATH?									
Σ	1 VES 2 (L-NO									
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
IYS	1 VES 2 PNO	1 ■ Inpetiant 2 □ ER/Out	patient 3 DOA		Home 5 Rasidenca	8 Other (Specify)	IN ILION OCCUP	150		
	1 Natural 5 Pending	(Month, Day, Year)		IURY	WORK?	200. DESCRIBE NOW				
В	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	r — A1 home, ferm,			281, LOCATION (Street	and Number or I	ber or Rural Route Number.		
COMPLETED	3 Suicros 6 Could not be 4 Hornicide determined City or Town, State)									
LE	29e. CERTIFIER Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(a) and menner as stated.									
ME	(Check only one) 2 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									
	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)									
BE (Sneam 1 roles our M6095 Detaker 14 1995									
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	Gregory Prohipowizz 600 N. Wolfe St Baltmore MD									
	31. OCT 1 7 1995 J	32 DEGISTRAR'S A	A COLOR							



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		1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Li	STATE OF MA		ERTIF						REG. NO.		YEAR 1.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yts. las	NE	IF UNDER	105	SM	DN	OCTO	BERL	1 9	75	X FH "
_		217 38 9386	1 X M 2 - F	54	YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE (Month 05/3	of BIRTH I, Day, Year) 11/41		Country) Mary	and
should	-	9a. FACILITY NAME (If not institution, gr				9b. CITY	TOWN C	OR LOCATI	ION OF DE	_	-/	9c. COUNT	- 45	
. 2, 3	5	Harbor Hospi				Ba1	timo	ore				N/A		
Pages	DIRECTOR	10a. STATE 10b. COU				Y, TOWN C		ION					10	d. INSIDE CITY
permit.		Delaware Ko	ent		Ha	rtly		. ZIP COD	£ .		_	I ton CITIZE		YES 2 NO
is.	FERAL	2268 Tower Ro	ad					199					S.A.	COUNTRY
21215-0020 If or attending physician, for use as the burlat-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 🔀			f yes, sp	ecify Cube	OF HISPAN III, Maxicai Specify	n, Puerto F	? (Specify Yea Ncan, etc.)	or No 1	4. RACE — Black, W Specify:	American Indian, hita, atc. White
21 for u	COMPLETED	15. DECEDENT'S E (Specify only highest gi Elementary/Secondary (0-12) 12th	EDUCATION rade completed) College (1-4 or 5+)	(G life	ECEDENT'S live kind of a b. Do NOT us CUCK	work done se retired.)	during mo	ON st of worldi	ng		KIND OF BUS			y
Z 2 2 3	E 111	17. FATHER'S NAME (First, Middle, Last)	Albert G. N	Mossmar	n			18. MOT			M. Li		an	
	2	19a. INFORMANT'S NAME (Type/Print) Alletta Mossma	an		268 C						er, City or Town			
ORE, 6 may be ector, page	20 1820	20a. METHOD OF DISPOSITION 1 □ Burlel 2 ▼ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	amoval from State	20b. PLACE						10/1		cation — ci		steta aryland
	examilier	21. SIGNATURE OF FUNERAL SERVICE	Mamuseur	1		22. Ge	NAME AN	e J.		e Fu	neral	Home	P.A.	
O. BOX 68760 ertificate be executed within 24 hours ing physician and completely filled in gigene prior to burial, cremation, or re	CERTIFICATION	23. PART I. Enter the diagraca, shock, or heart failu IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Rup Tu DUE TO (OF	on each line	OUENCE OF	A /								Approximate Interval Batween Onset and Death
ADS treed by the		PART II. Other algolificant conditions	d.	eth but not r	resulting	in the un	derlying	ceuse (given in i	Part I.	24s. WAS AN			RE AUTOPSY FINDINGS
RECO requires the	MED	DID TOBACCO USE CON	STRIBLITE TO CALL	CE OF DEA	TII VE		N			_	1 YES 2		CO OF	MPLETION OF CAUSE DEATH? YES 2 NO
TAL The law ite has that ate Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	OTHER	only one)		ERTAIN					
OF V PHYSICIA this certif with the	BY PHYS	27. MANNER OF DEATH 1 Metural 5 Pending Investigation Investigation	1. Inpatient 2 EF	JURY	28b. TIM		28c. INJU	JRY AT	NO NO	-	(Specify) CRIBE HOW IN	NURY OCCU	RED	
S 2 2 2 4	히밀	3 Suicide 8 Could not 4 Homicide determined		NJURY — At ho . (Specify)	me, farm, s	Hreet, fact	ory, office			281. LOCA City o	TION (Street a or Town, State)	nd Number or	Rurel Route	Number,
Z 4 2 2	: 5		YSICIAN: To the best of my INER: On the basis of axam											d manner as stated,
TO THE HOSPI TO THE FUNER be filed within	TO BE C	29b. SIGNATURE AND TITLE OF CERTIF	66	n	vo.			29c. LICE	24	BER 070	2	29d. DATE S	C.	nth, Dey, Year)
_ 10	¥	31. OC TLE (MS/M 995")	WHO COMPLETED CAUSE OF	HAR	M 27) (Type, BOR		spi	TALC	Cent	TER	3001	1 5.1	BNE	EST. 21de



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to removal.

IMPORTANT: If them 28 is marked, or them 23 shows any linker, or other traumatte event, the market has marked.

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTRAR		CERTIF	ICATE OF L	JEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) HARRY	LEE		MA	SON	2. DATE OF DEATH DO OCTOBER 9	, 1995	3. TIME OF DEATH 10:15P M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)		IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign
	219-66-5465	7 ∑ M 2 □ F	36 YRS.		HOURS MIN.	(Month, Day, Yber) JANUAR 1	Cour	
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN OR			9c. COUNTY OF	The state of the s
DIRECTOR	THE JOHNS HOPE	KINS HOSPITA	AL	BALTI	MORE CIT	ΓY	N/A	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY						14//	
E	MD 100. COUNTY	/		Y, TOWH OR LOCATIO				10d, INSIDE CITY LIMITS?
		N/A	E	ALTIMOR				1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER			101. 2	IP CODE		10g. CITIZEN OF	WHAT COUNTRY?
₩	2208 CECIL AVE				21218		II.S.	Α.
5	11. MARITAL STATUS 1 West Married 2 Married	12. WAS OECEDENT EVER I FORCES? 1 YES	N U.S. ARMED			IC ORIGIN? (Specify Yes	or No — 14. RAG	CE — American Indian, ck, White, stc.
¥	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TES 2	NO Specify	The state of the s		ÄCK
	15. DECEDENT'S EDUCA	TION	44. 0505051710					JACK
COMPLETED	(Specify only highest grade or	ompleted)		USUAL OCCUPATION work done during most		16b. KIND OF BUS	SINESS/INDUSTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A		EN HELP	r D	DECMI	JRANT	
NO O	17. FATHER'S NAME (First, Middle, Last)	N/A				ME (First, Middle, Maiden		
		ONES						
BE	19a. INFORMANT'S NAME (Type/Print)		19h MAII INC		ELIZABI	E'1'H loute Number, City or Town	MAS	ON
2	ELIZABETH MASON							
8	20a. METHOO OF DISPOSITION	200		OF DISPOSITION (Name		LTIMORE,		
	1 C Buriel 2 Cremation 3 Remov	rai from State cen	netery, crematory or o	ther placal			CATION — City or 1	lown, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICE	MSEE /	ZION	CEMETERY	ADDRESS OF FAC		ANSDOW	
	9		- 1			BELLS	FUNER	AL HOME
	Devery	Crome	4 til	1129 N	. CARC	DLINE ST.	BALTO	.,MD21213
	23. PART / Enter the diseases or co shock, or heart failure. Li	mplications that cause	the death. Do r	ot enter the mode	of dying, such	as cardiac or respi	ratory arrest,	Approximata
	IMMEDIATE CAUSE (Final	at only one codes on e	acir iiile.					Interval Between Onset and Death
	disease or condition resulting in death)	statu	epilent	leus				+ DAY
		DUE TO (OR AS A	CONSCOUENCE OF	7:	A .		<u> </u>	2
Z	Sequentially list conditions, b.	acqui	red in	rmunod	eticien	cy Synd	frome	TO YEARS
CERTIFICATION	If any, leeding to immediate	DUE TO YOR AS A	CONSEQUENCE OF	7):		7 0		
2	CAUSE (Diseese or injury	0115 70 (05 45	20112501151125					
Ē	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF	·):				
	d.							
1	PART II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying o	ause given in i	Part I. 24s. WAS AN		b. WERE AUTOPSY FINDINGS
EDICAL						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 🗀 YES 2	≫C NO	OF DEATH?
Σ	DID TOBACCO USE CONTRI	RUTE TO CAUSE O	E DEATH VE	S D NO D	UNCERTAIN	_ R21		1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEAT		UNCERIAII	ומו		
PHYSICIAN:		HOSPITAL:		OTHER:	- Service			
ΞĖ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	4 Nursing Home E OF 28c. INJUR		28d. DESCRIBE HOW IF	HIEV OCCUBED	
	1 Netural 5 Pending	(Month, Day, Year)		URY WORK		200. DESCRIBE NOW II	AJOHT OCCUMED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, farm, s			281. LOCATION (Street a	and Mumber or Russi	Bouts Number
	4 Homicide 8 Could not be determined	building, atc. (Spec	elfy)	table, y, billow		City or Town, State)	ING NUMBER OF PIGNE	Piodie Patricer,
COMPLET	29a. CERTIFIER							
Δ		AN: To the best of my know						
8		On the beals of examination	n and/or investigatio	n, in my opinion, deat	th occured at the t	time, data and place, and	d dua to the cause	(a) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER			2	9c. LICENSE NUM			D (Month, Day, Year)
5	DV Jano	PHYS			N.	2619	Octob	er 10, 1795
	30. NAME AND ADDRESS OF PERSON WHO	0				1.6 11	1	er 10, 1995 Baltimore
	Isaac E.	SILVERMA	1 113	. Jo	hos Ho	pkins H	espital;	Daltimore
	OCT 1 7 1000	32. REGISTRAR'S SIGN	ATURE		·	1	,	
- 7	VC1 1 71995 d.1.	A. A.	4112					
			n EZ					DMMM.16 Rev 1/89

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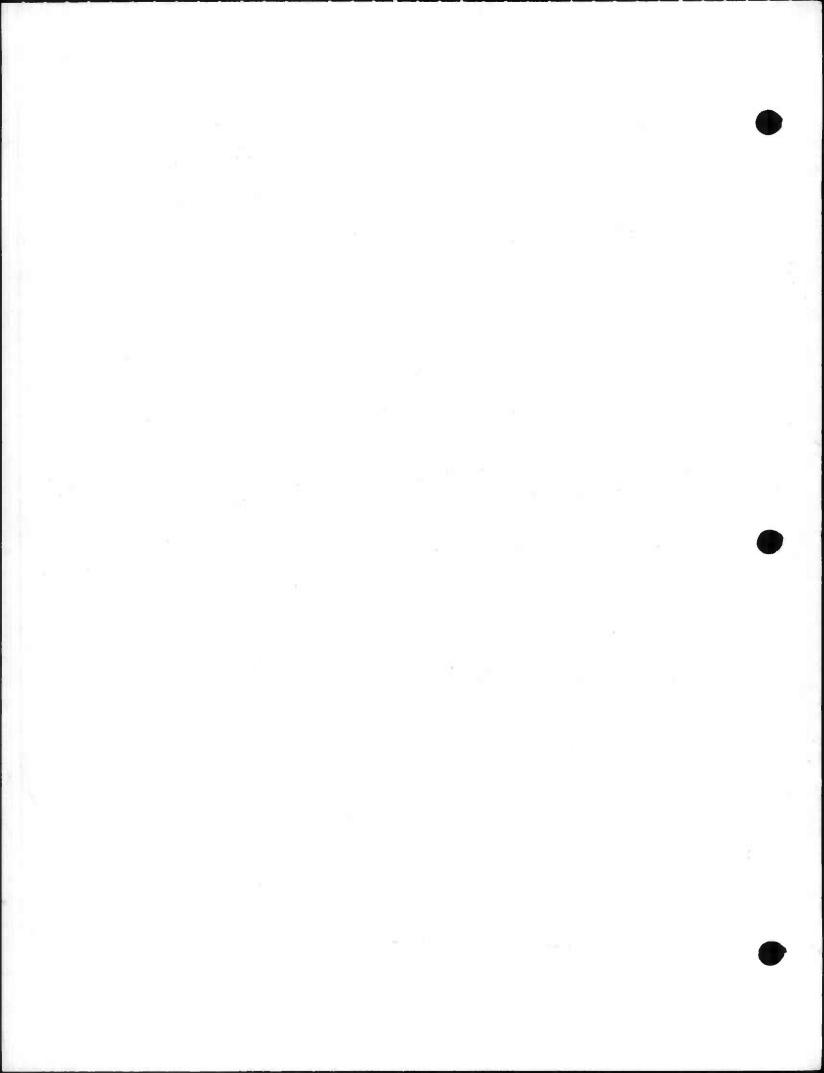
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. It hours after death. Page 6 may be TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept. Of Health and Mental Hygines prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be a	î	2	age	9
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be find within 72 hours after death with the State Dept. or Health and Mertal Hygiene prior to burial, cremation, or remonal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner mi	2	E	Of. p	TS.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Part of the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral doe find within Tz hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examine	2	9 90	irect	Ē
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-2s hours after death to THE FUNERAL DIRECTOR: After this certificate has engined by the attending physician and completely filled in by the fune be fined within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burist, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical exam		Se.	2	ine
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the be find within 72 hours after death with the State Degr. of Health and Mertal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical e	ļ	leath	fune	хаш
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours all TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by be find within TZ hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or near IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medic	5	her d	8	al a
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hour solutions. The law requires that the death certificate be executed within 25 hours after death with the State Dept. of Health and Mental Hygiene prior to burist, cremation, or IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the me		Sa	9	die
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. 25 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill be find within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, ceremation IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the		Poe	. pa	B
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: TO THE FUNERAL DIRECTOR: After this certificate within 72 hours after death with the SI MPORTANT: If Item 28 is marked, or It		The	ate h	en en
TO THE HOSPITAL OR ATTENDING PHYSICS TO THE FUNERAL DIRECTOR: After this cer be fied within 72 hours after death with IMPORTANT: If Item 28 is marked, (AN	tifica	- N
TO THE HOSPITAL OR ATTENDING PHYOTO THE FUNERAL DIRECTOR: After this be fied within 72 hours after death within 17 hours after death within 17 hours after market IMPORTANT; If Nem 28 is market		SIC	93	d,
TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after dealt IMPORTANT: If Item 28 Is mi	,	PH	#	arke
TO THE HOSPITAL OR ATTENI TO THE FUNERAL DIRECTOR: be filed within 72 hours after IMPORTANT: If Nem 28 is)	SNIC	Affei	T T
TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2)	TEN	OR:	00
TO THE HOSPITAL OF TO THE FUNERAL DII be filed within 72 hou IMPORTANT: If 166		3 AT	RECT	E Z
TO THE HOSPITA TO THE FUNERAL BE filed within 72 IMPORTANT: II	1	10	TO J	9
TO THE HOS TO THE FUN be filed withi		PITA	ERAI	1.1
THE THE PER FILE		28	FUN	TAN
222		품	置	POR
		2	2	Z P

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. APGISTRAD'S SIGNATURE

	1 - STATE STATE	OF MARYLAND /	DEPAR	TMENT OF	HEALTH F DEA	AND		E	5 3	1165			
	1. DECEDENT'S NAME (First, Middle, Lest) Charles Lew				DEA	A	2. DATE OF DEATH MONTH DI		GYEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 451-40-4028 1 ☑ M 2	IF UNDER 1 YEAR MONTHS DAYS		24 HRS.	7. DATE OF BIRTH (Month, Day, Year) June 15, 1	934	BIRTHPLACE (State or Foreign Country) Texas						
СТОВ	98. FACILITY NAME (If not institution, give street and number Harford Memorial Hospi	•		96. CITY, TOWN	OR LOCATI	ON OF DE	EATH	9c. CO	unty of DE.	ATH			
DIREC	100. STATE 100. COUNTY Maryland Harford		10d. INSIDE CITY LIMITS? 1 YES 2 NO										
VERAL	100. STREET AND NUMBER 601 Cornell Street - A		AT COUNTRY?										
BY FUN	1 Never Married 2 Narried FORCES	CEDENT EVER IN U.S. ARI ? 1 1 YES 2 N GIVE WAR OR DATES		If yes,		n, Mexice	IIC ORIGIN? (Specify Yea n, Puerto Rican, atc.)	or No-		- American Indian, White, etc. White			
once.	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Gh life.	ve kind of w Do NOT use	usual occupa fork done during in nettred.)	nost of working	פי	Apartme		IOUSTRY				
BE COI	17. FATHER'S NAME (First, Middle, Last) Vernon Murphy						ME (First, Middle, Malden						
TO TO	Beatrice Murphy (wife	6	01 C	ornell	Stree	t-AK	Poute Number, City or Town Ot. 201-Bal	n, Sture, Zi Etimo	ore, h	MD. 21001			
er must	1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LICENSEE ROUTE of LICENSEE ROUTE OF LICENSEE ROUTE												
or other traumatic event, the medical examiner must be notitied at once. FRTIFICATION TO BE COM	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, immediate Cause (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):												
y, or other traumatic	cause. Enter UNDERLYING CAUSE (Disease or Injury	JE TO (OR AS A CONSEO											
23 shows any injury, AN: MEDICAL CE	PART II. Other significent conditions contribution Diakefee new July 100 TOBACCO USE CONTRIBUTE TO	Pul mos CAUSE OF DEAT	H YE	FIL S NO	UNC	iven in	PERFOR	MED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO			
Y PHYSICI	27. MANNER OF DEATH 28a. OA (Mc			OF 28c. II			8 Other (Specify) 28d. DE\$CRIBE HOW II	URY OC	CURED				
Z8 is	3 Suicide 28e. PL	ACE OF INJURY — At horr Iding, etc. (Specify)	ne, farm, st				28f. LOCATION (Street a City or Town, State)	nd Numbe	or Aural Rou	ute Number,			
M M	29e, CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the beautiful department of									and menner as stated,			
TO BE COI	290. SIGNATURE AND TITLE OF CERTIFIER Pere See (2) 30. NAME AND ADDRESS OF PERSON WHO COMPLETE	Ront		MP	29c. LICE	NSE NUM			TE SIONED (A	Month, Day, Year)			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float feath. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunta-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	FOR STATE OF MARYLAND C				ALTH AND	MENTA	L HYGIENI	Ε		
	1. DECEDENT'S NAME (First, Middle, Lest)						OF DEATH			3. TIME OF DEATH
	CHRISTINA JOHNSON MAYOR					MONT	TORER		190	5 7AM M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Id	ast birthday)	IF UNDER 1		IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH h, Day, Year)			HPLACE (State or Foreign
	086-24-9666 1 M 2 X F 63 9a. FACILITY NAME (If not institution, give street and number)	YRS.	1 11		LOCATION OF D	FE		1932 9c. COU		OOKLYN N.Y
DIRECTOR	ANNE ARUNDEL MEDICAL CENTER	?	ANNA	APOI	IS			ANN	EA	RUNDEL
F	10a. STATE 10b. COUNTY		Y, TOWN OR							10d, INSIDE CITY LIMITS?
	MD. ANNE ARUNDEL	Ar	NAPO							1 X YES 2 NO
FUNERAL	2731 GINGERVIEW LANE			101. 2	21401			USA		WHAT COUNTRY?
11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES X NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No-Hi yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — Ame Black, Whita, Specify: 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No-Hi yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. YES 2 X XO Specify: WHITE										offy:
0			USUAL OCC			168	, KIND OF BUS	INESS/INC		
COMPLETED		e. Do NOT u	se retired.)	any most	or working	7	AIRLIN	IES		
MP		TEWA	RDES	S						
	17. FATHER'S NAME (First, Middle, Lest) FRANK EMIL JOHNSON				18. MOTHER'S NA	AME (First,	Middle, Maiden	Sumame)		
BE		06 84 8 11 4840	4000000	/O	OLGA d Number or Rural	C	h Oh T.		0.41	
2					JIN RD					21032
	20a. METHOD OF DISPOSITION 20b. PLACE		OF DISPOSIT			DAT	_	CATION -		
	1 Burial 2 Cremation 3 Removal from State cemetery, ca	remetory or o				10-	-16 BA			10 2300
	21. SIGNATURE OF FUNEBAL SERVICE LICENSEE		22. N	AME AND	ADDRESS OF FA	CILITY				
	Dalref J Chill				DESTY I				21	1401
	23. PART I, Enter the disease, or complications that caused the dispose, or heart failure. List pnly ons cause on each lin		not enter t	he mod	e of dying, aud	ch aa car	diac or reapi	ratory ar	reat,	Approximata
	IMMEDIATE CAUSE (Final disease or condition resulting in desth)	milw	ri							Interval Batween Onset and Daath
	DUE TO JOR AS A CONS	EQUENCE O	F):	4						
NO O	Sequentially list conditions,	MENTER		enl	orutes					5 days
CERTIFICATION	If any, leading to immediate couse. Enter UNDERLYING	die	, 1							
띮	CAUSE (Disease or injury that initiated events OUE TO JOH AS A CONST	EQUENCE O	Pj:							
FIRT	resulting in desth) LAST									
	PART II. Other significant conditions contributing to death but not	resulting	In the unc	jerivina	ceuse given in	Part I.	24a. WAS AN	AUTOPSY	24	b. WERE AUTOPSY FINDINGS
CAL				, , ,			PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						_	1 TYES 2	Ano.		OF DEATH?
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH Y	ES N	10 🛛	UNCERTAI	N 🗆				
SIA		ACE OF DEA	TH (Check o	-						
YSIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetlent	3 🗆 DOA	4 Nursi		5 Residence	6 🗆 Oth	er (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28b. TIN	JURY M	28c. INJU WOR 1 YE		28d. DE	SCRIBE HOW I	NJURY OC	CURED	
E	2 Accident Investigation 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At 1 building, etc. (Specify)	nome, farm,	street, facto	ry, office		281. LO	CATION (Street a or Town, State)	and Numbe	r or Rural	Route Number,
	29a. CERTIFIER	de edh e e e u							4.4	
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the best of axamination and/o									(a) and manner as stated.
BE	296. SIGNAY GREAND TITLE OF CERTIFIER VALUE STATE SUCH SUCH MS	7			29c. LICENSE NU	IMBER 70	1	29d. DAT	E SIGNE	D (Month, Day, Year)
5	39 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	EM 27) (Type	Print)	LY	AVE, AN	NAPA	ILIC N	1) 2	104	1
	31. DATE FILED (Month, Day, Year) 32. DEGISTRAR'S SIGNATURE	7//	1000	,	146) 148	MILLO	-12/1	DO	10 (1
	OCT 1 71995 Juli Student	while,								

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG.	NO.	
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF CEATN
	IDA G.	MAYERS				OCT. 14		12:30 A M
		5. SEX 6. AGE (In yr		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTNPLACE (State or Foreign Country)
	061-28-5357	1 □ M 2 💢 F 87	YRS.	NTHS DAYS	HOURS MIN.	Dec 23,	1907	MD
	9a, FACILITY NAME (If not institution, give street	et and number)	91	CITY, TOWN	R LOCATION OF DE		9c. COUNTY	OF DEATH
DIRECTOR	7121 PARK HEIGHTS	AVE. APT.#80	01	BALT	IMORE			N/A
<u>ا</u> پي	10e, STATE 10b, COUNTY		10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
ā	MD N/A			BALTI	MORE			1X YES 2 □ NO
A	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZE	OF WHAT COUNTRY?
FUNERAL	7121 PARK HEIG	HTS AVE, APT	. 801		21215			USA
5		12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2			ENDENT OF NISPAN			. RACE — American Indian, Black, White, etc.
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES	3X		2 NO Specify			Specify: WHITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		DECEDENT'S US	UAL OCCUPATIO	ON st of working	16b. KIND OF	BUSINESS/INDUS	TRY
	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of worl life. Do NOT use n	etired.)	ot of working			
<u> </u>	12		SALES	PERSON	1	CHI	LDREN'S	CLOTHING
ଟ୍ର	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	ME (First, Middle, Me	_	
BE	Morris	Alexan	-		Rose			ston
ဥ	190. INFORMANT'S NAME (Type/Print) STEWART GOLDSTET	·Nī			nd Number or Rural R			ode)
	20a. METHOD OF DISPOSITION		ACE AND DATE OF I				LOCATION - CIT	or Town State
	1X Burial 2 Cremation 3 Remov	rel from State cemeters	y, crematory or other h El Men	place)	10/15			stown, MD
	21. SIGNATURE OF FUNDRAL SERVICE LICE		II DI Men	22. NAME A	D ADDRESS OF FAC	CILITY		COWITY TID
	1.041	Citt.			LEVINSON			
	HERN IN	· unu						ORE, MD 21215
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplicetions that caused the ist only one cause on each	e deeth. Do not Ilna.	enter the mo	de of dying, such	ss cardlec or re	espiratory arres	t, Approximats interval Between
	IMMEDIATE CAUSE (Final disease or condition	C 0 107	2					Onset and Death
	resulting in desth)	DUE TO (OR AS A CO	-104	00/100	OR!	NARI	-57	401015
		DUE TO (OR AS A CO	NSEQUENCE OF):	10 -72	URE			1 2020
<u>8</u>	Sequentially list conditions, b.	OUE TO (OR AS A CO	NSEQUENCE OF:	NIG	UKE			600
ΕĮ	if any, leading to immediate cause. Enter UNDERLYING	1100 <	1 1100					20720
띮	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST							
ü	DART II ON THE STATE OF THE STA							
SAL	PART II. Other significant conditions	~ >		_	g cause given in		S AN AUTOPSY REOBMED?	24b. WERE AUTOPSY FINDINGS - AMAILABLE PRIOR TO
٥	Na/ ZNF/8	TYLIN'S W	7350	SE		1 _ YE	8.24 NO	OF DEATH?
¥					}		,	1 TYES 2 NO
Z	DID TOBACCO USE CONTRI				UNCERTAIN	1 📗		
SICIAN: ME		HOSPITAL:	PLACE OF DEATH	(Check only one) THER:	7			
YS		1 Inpatient 2 ER/Outpatie	nt 3 🗆 DOA 4	☐ Nursing Hon	1	6 Other (Specify)		
PHY	27. MANNER OF DEATN Netural 5 Pending	(Month, Day, Year)	28b. TIME (Y WO	URY ÁT PRK?	28d. DESCRIBE H	OW INJURY OCCU	RED
B	2 Accident Investigation	28s. PLACE OF INJURY —	At home form etre		YES 2 NO	204 LOCATION (C)	mat and Mumber as	Rural Route Number,
	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specify)	At Hollie, Termi, ette	et, metory, onte	.	Gity or Town, S		nure noute number,
COMPLETE	29a. CERTIFIER		SANSARITI III III		270000000000000000000000000000000000000		- HISOS	
ξ	anal	IAN: To the beat of my knowledg : On the basis of exemination an						
႘			- Investigation,	my opinion, (
8	29h. SIGNATUM, AND TITLE OF CERTIFIER	holes	الم العدا	0	29c. LICENSE NUM	IBER	29d. DATE S	SIGNED (Month, Day, Year)
	18242 4771	1 1600012			1124	00/	10	114141
၉	30 NAME AND ADDRESS OF DEDROM WILL	COMPLETED CALLES OF ASSET	TITEM AT ATTER A	daet.	10		-	110
2	30. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF OEATH	TITEM 27) (Type, Pr	int)	1300	かっト	203	21208

•

5. SEX

1 M 2 - F

JOSEPH

STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

214-01-6864

1. DECEDENT'S NAME (First, Middle, Last)

1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DAYS

HOURS

NIEDZIALKOWSKI

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

82

YEAR

95

9c. COUNTY OF DEATH

n/a

USA

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 XYES 2 NO

Approximate

10/4/93

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 - YES 2 NO

OF DEATH?

interval Between

Onset and Death

MARYLAND

10g, CITIZEN OF WHAT COUNTRY?

Specify: WHITE

5.40 AM

a tolareg. W

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year,

2-18-13

10

215-0020	attending physician.	ed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit perm
BALTIMORE, MARYLAND 21215-0020	retained by the hospital or	5 should be detached for
ALTIMORE,	death. Page 6 may be	funeral director, page
68760 B	ecuted within 24 hours after	nd completely filled in by th
DRDS, P.O. BOX 68760	that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	by the attending physician a
0	=	∇

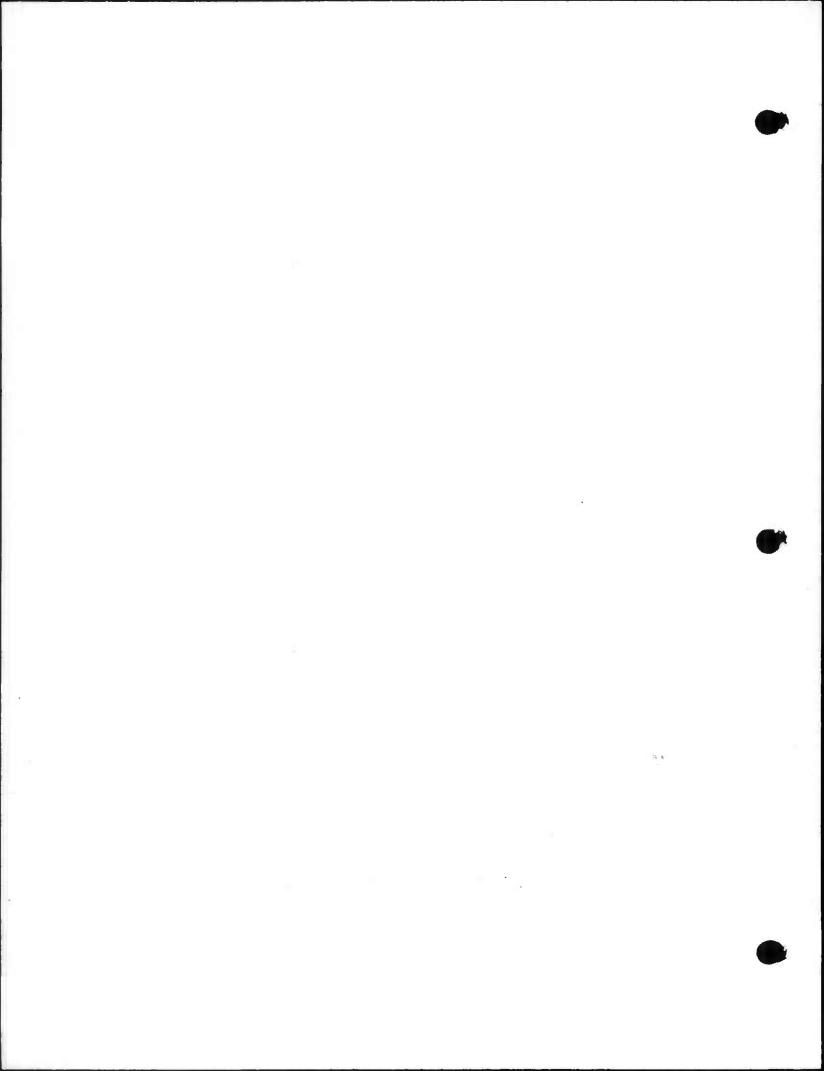
Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 96. CITY, TOWN OR LOCATION OF DEATH DIRECTOR GOOD SAMARITAN HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION maryland N/A BALTIMORE 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 3139 DILLON STREET 21224 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married if yes, specify Cube 1 ☐ YES 2 💢 NO BY 3 Widowed 4 Divorced Specify: COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) YEARS WOOD SHOP SUPERVISOR MD. STATE DEPT. CORRECTED 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname, Niedzialkowski ADAM NIEDIALKOWSKI notified at STANISLAWA B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niedzialkowsk 2 CECELIA #3139 DILLON STREET BALTO. MD. 21224 pe 20s. METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must STP: "STANITSCAUS CEMETERY 10-13 BALTO. MD. 4 Donation 5 Other (Specify) examiner SUGMATURE OF FUNERAL SERVICE EICENSEE 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. medical diseases, or complications that caused the deeth. Do not enter the mode of dying, such ea cardiec or reapiratory arrest, 23. PART I. Enter the shock, or heart falls one cause on each line. 0 **IMMEDIATE CAUSE (Fine)** the cremation, disease or condition neustones resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF). burial. -VA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initisted events resulting in desth) LAST 6 injury, DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL and any been signed at. of Health 1 YES 2 NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN IN PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 TYES 2 NO 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending M 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Flural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide determined Nem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN, To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL TO THE FUNERAL ID be filed within 72 h 2 MEDICAL EXAMINER: the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE WW W D22652 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 LOCHRAVEN BLUD BALTIMORE 31. DATE FILED (Month, Day, Year)

29d. PATE SIGNED (Month, Day, Year)

-10/16/15

MD 2123 9

32. REGISTRAR'S SIGNATURE Julia Stavelson Rardall



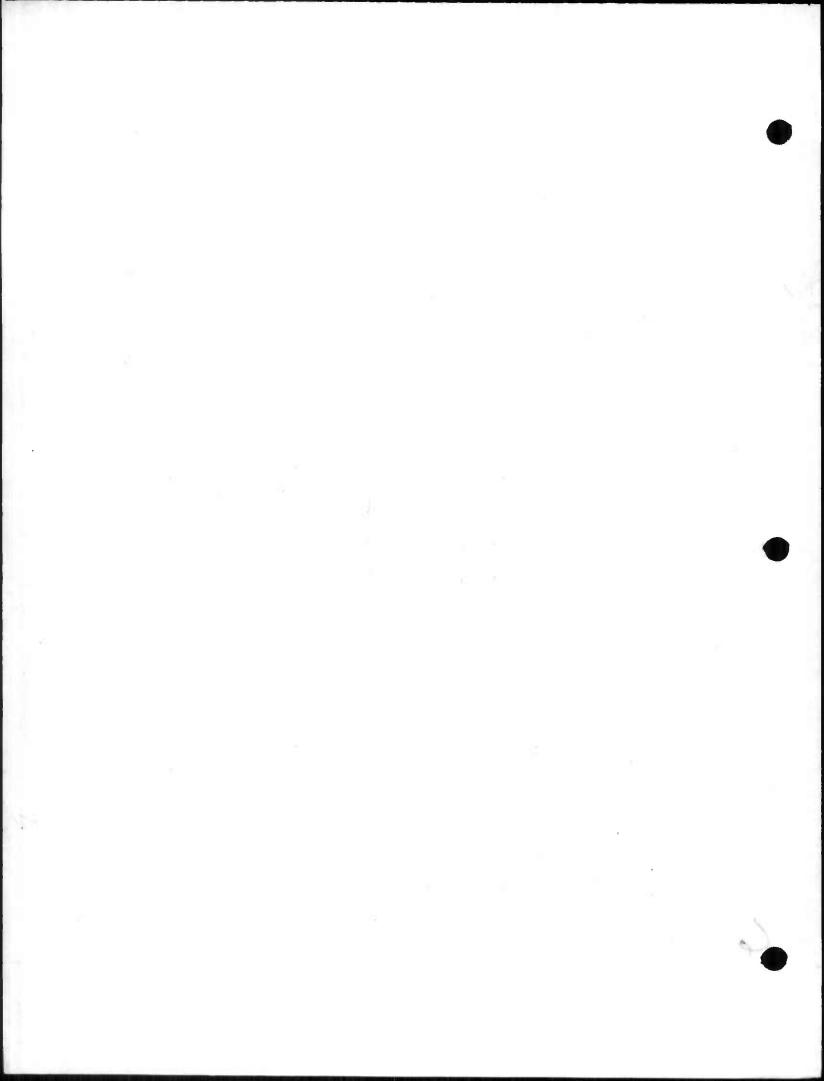
burial-transit use as the 10 detached once. 2 F notified pe must examiner filled in by the medical the completely event. and com traumatic . ve t. Hygiene prim other the attending p 10 any injury. OR ATTENDING PHYSICIAN: The law requires that the signed by the shows a Dept. Item the State I 10 with t marked, DIRECTOR: After the hours after death water 18 is mark TO THE HOSPITAL OF THE FUNERAL OF SE FILED WITHIN 72 THE IMPORTANT: If It

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1, DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH OCTOBER 12,1995 13:20 GREGORY NATHANTEL 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign A SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5 SEY IF UNDER I YEAR IF UNDER 24 HRS. DAVE HOURS 46 SEPT. 110 M 2 | F YRS. 218-46-8716 11,49 9b. CITY, TOWN OR LOCATION OF DEATH 9a. FACILITY NAME (If not institution, give street and number DIRECTOR THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD N/A 1 X YES 2 | NO BALTIMORE CITY 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE 4607 FREEDOMWAY WEST 21213 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 X Married 1 TES 2 NO Specify: BY 3 Wildowed 4 Divorced BLACK ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 18h KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL CONSTRUCTION WORKER HARVIEW CONSTRUCTION 12th N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARCUS NOLE FLOSSIE MAE GENNINGS BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) DOROTHY NOLE 4607 FREEDOMWAY WEST BALTIMORE, MD. 21213 20a. METHOD OF DISPOSITION

TO Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 6 Other (Specify) DULANEY VALLEY MEMOR 10/18 PADONIA, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD21213 Approximats Enter the disaptes, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, shock, or near failure. List only one cause on each line. Interval Batwesn Onset and Death IMMEDIATE CAUSE (Final disesse or condition hemorrhage intracerebral reaulting in dasth) DUE TO (OR AS A CONSEQUENCE OF): travenous CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF If sny, issding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TYES 2 TNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO Z UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 YES 2 Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 26c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation BY 2 Accident 28a. PLACE OF INJURY — At home, Jerm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 4 Homicide determined CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(e) and manner as stated. (Check only one) basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated 29b. SIGNATORIE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 10 Etober 13 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE





3:45 PM

Approximate Interval Between Onset and Death 4 HOURS

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

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	1 - FOR STATE REGISTRAR		STATE OF MA	RYLAND	/ DEPAI	RTMEN	T OF	HEALTH AN	D MEN		YGIEN EG. NO	E		
	1. DECEDENT'S NAME (Fire							-		DATE OF D	EATH			3. TIME OF OEATH
	JOSEP		NOWACK	/						CI	14		YEAR	3:45
	4. SOCIAL SECURITY NUM			. AGE (In yrs.	last birthday)	IF UNDI	DAYE		18. 7. C	ATE OF B	IRTN Wast		8. BIRTI	HPLACE (State or Foreign
	212-44-327		1 M 2 F	49	YRS.	MONTHS	DATE	HOURS MH	0.8	3-25	-19	46		yland
B	90. FACILITY NAME (If not)					9b. Cf1		n or Location of				9c. COU	NTY OF D	
티	RESIDENCE OF DE		товртсат			<u> </u>	Ба	TCIMOL	-				14 / 13	
DIRECTOR	10a. STATE	10b. COUNT				TY, TOWN								10d. INSIDE CITY
	rld.	N/	A			Balt	imo	re						1 X YES 2 NO
RAI	312 S. Ann		_					10f. ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	Stree				100		2123					S.A.	
	1 Never Married 2	Merried	12. WAS DECEDENT E FORCES? 1	YES 2%		13	If yes,	ECENDENT OF HIS specify Cuban, Me	xicen, Pu	RIGIN? (Sp erto Rican,	ecify Yes , etc.)	or No-	14. RACI Black	E — American Indian, k, White, etc.
ВУ	3 Widowed 4 X Div	rorced	IF YES, GIVE WAR	OR DATES			1 Y	ES 2 X NO S	pecify:				Spec W.	_{my:} hite
ETED		CEDENT'S EDU		16a.	DECEDENT'S	work done	during i	TION most of working		16b. KING	OF BUS	SINESS/INC		
빌	Elementary/Secondary	(0-12)	College (1-4 or 5 +)		life. Do NOT u	ise retired.)			70	1		a	
COMPL	17. FATHER'S NAME (First, I	Madelle desail	4	T	ept.	OI K	lecr	eation				ore (City	
	John E. N							Marie						
8	19a. INFORMANT'S NAME				105 MAII IN	ADDRE	26 (0)	t end Number or Ru					• • • •	
5	Elizabeth A							ark Road						128
	20a. METHOD OF DISPOSI	TION		1	E AND OATE							CATION		
	1 X Burlel 2 Cremati 4 Donation 5 Othe		oval from State	Cametery.	Lawn	Cem.)	10/19	1			1time		
	21. SIGNATURE OF FUNERAL BEHAVIOR LICENSEE 22. NAME AND ADDRESS OF FACILITY 21.231													
	Lilly & Zeiler Inc. 1901 Eastern Av													
Н	23. PART i. Enter the c	diseases, or o	complications that c	aused the	death. Do									
	snock, or r	nesit fellure.	List only one cause	on each li	ne.	not ente		node or dying,	auch se	CSIGISC	oi respi	ratory sri	eat,	Approximate interval Between
	IMMEDIATE CAUSE (FI	nsi	,	40016	M	100	10	DIAL	1.15	10	-	104	,	Onset and De
	resulting in death)		DUE TO (OI	R AS A CONS	SEQUENCE C	IF):	3/4	27112	777	AK	C /	UN		4 Hours
z			b. A	THER	ROSCL	ERC	2710	c HE.	ART)1:	SEA	SE	
CERTIFICATION	Sequentially list condi- if sny, lesding to imme	diate		R AS A CONS										
2	CAUSE (Disease or inj		c			_								
	that initiated events resulting in deeth) LAS	ST	DOE TO (OF	R AS A CONS	SECUENCE C	F):								
CAL CE			d											-
AL	PART ii. Other algnific				t resulting	in the u	nderlyi	ing cause given	in Part		WAS AN PERFOR	AUTOPSY	24b	WERE AUTOPSY FINDIN
MEDICAL	CHRONI	C AL	COHALISI	И							YES 2	-		COMPLETION OF CAUSE OF DEATH?
														1 YES 2 NO
ä	DID TOBACCO U		RIBUTE TO CAUS	SE OF DE	ATH Y	ES 🗆	NO	☐ UNCERT	AIN E	3				
S	25. WAS CASE REFERRED 1 EXAMINER?	TO MEDICAL	HOSPITAL:	26. PL	ACE OF DEA	TH (Check	_	(0)						
PHYSICIAN:	1 TYES 2 NO		1 Impatient 2 E		_	4 🗆 Nu		ome 5 🗆 Residen	ce 6 🗆 (Other (Spe	cify)			
F	27. MANNER OF DEATH	Pending	28e. DATE OF IN. (Month, Day,		28b. TIN	IE OF JURY	٧	NJURY AT VORK?	28d.	DESCRIB	E NOW II	JURY OC	CURED	
B	2 Accident	Investigation	200 DI ACE OF II	AL BURNY AL		M		YES 2 NO						
	3 Suicide 8 4 Homicide	Could not be determined	28e. PLACE OF II building, etc	(Specify)	nome, farm,	streel, fed	ctory, of	fice	281.	City or Tow	(Street e	nd Number	or Rural F	Route Number,
Ē	29e. CERTIFIER	TIEVING SINCE												
COMPL	(Check only 1 12 CEH		CIAN: To the best of my R: On the basis of exem											
- 11	29b. SIGNATURE AND TITL				veriyeti		openiiOI),	7		Acre and b	race, and			
BE		3och		8				29c. LICENSE		-0				(Month, Day, Year)
2	20 NAME AND ADDRESS O							10-	265	94		- 0	(1)	14 1995

100

BROADWAY

BALTIMORE, MD

RIAZ

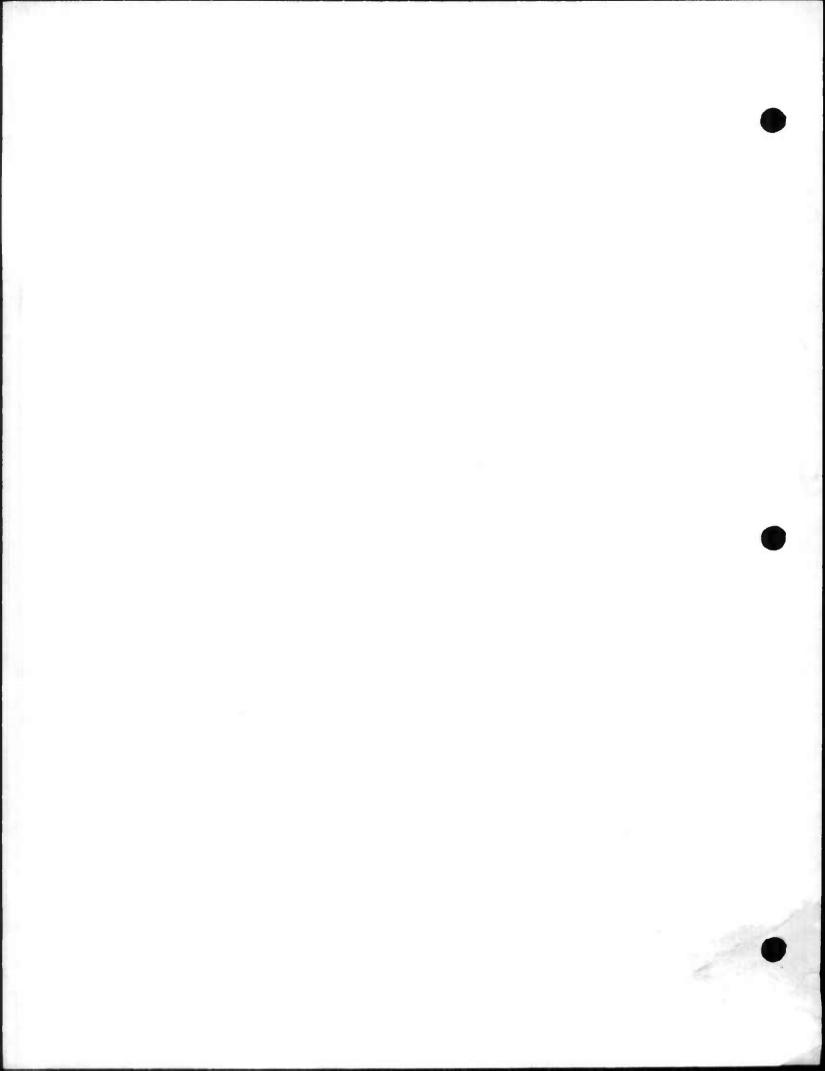
31. DATE FILED (Month, Day, Year) OCT 1 7 1995

BOKHARI

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

M.D

OHMH-16 Rev 1/89



3. TIME OF DEATH

MD 21215

Approximate Interval Between Onset and Death 12 HRS

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

2.09

REG. NO. 2. DATE OF DEATH

OCT

LEONE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Leone Nahum

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

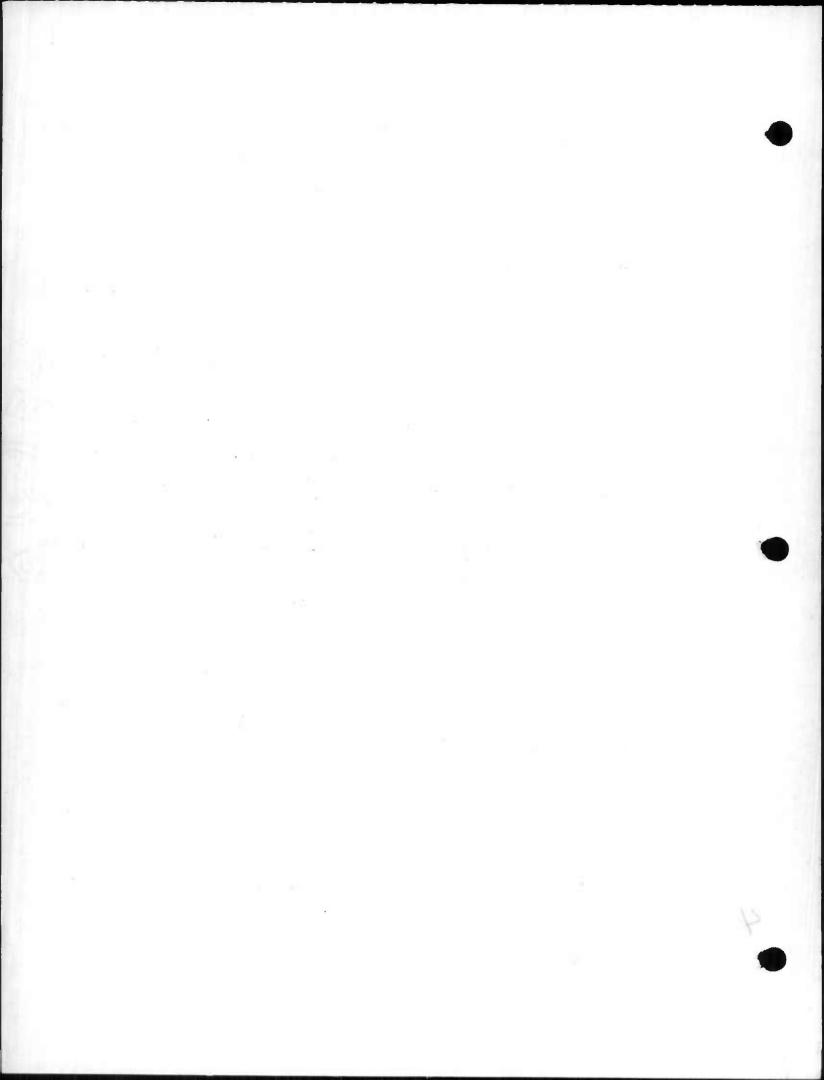
NAHUM.

1 -

BOX 68760 DIVISION OF VITAL RECORDS, P.O.

П	4. SOCIAL SECURITY HUMBER 242-72-2052	5. SEX	6. AGE (In	yrs. lest birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24	HRS.	7. DATE OF BIRTH (Month, Day Year) DEC. 17,1	899	8. BIRTHPL Country) TURK	CE (State or Foreign
	9e. FACILITY NAME (If not institution, gir	e etreet and number)			9b. CITY T	DWN C	OR LOCATION	OF DE			HTY OF DEAT	
8	CHURCH HOME & HO						MORE	0, 50	ni.	N/A	THE OF BEAT	
CTOR	RESIDENCE OF DECEDENT											
DIRE	MARYLAND 10b. COU	BALTI	MORE	10c. Cl	TY, TOWN OR BA	LT	IMORE				1	d. IHSIDE CITY LIMITS? YES 2 X NO
FUNERAL	7921 LONG MEADOW	ROAD				101	212	208		10g. CIT	USA	
2	11. MARITAL STATUS 1 Hever Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDED FORCES? IF YES, GIVE	1 YES	2 ZNO	14	res, sp	ecify Cuban,		IC ORIGIN? (Specify Yos, Puerto Ricen, etc.)	e or No—		American Indian, thite, etc.
3	15. DECEDENT'S E (Specify only highest gi		1	16a. DECEDENT'S	S USUAL OCC				18b. KIHD OF BU	JSIHESS/IHI	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Ille. Do NOT					Comme		_BANKI	NG
E COMPL	17, FATHER'S NAME (First, Middle, Lest) ALBER	T		NAHU	īM		18. MOTHER		ME (First, Middle, Melde JLTANA	n Surneme)	υ	nknown
0	19e. INFORMANT'S HAME (Type/Print)			19b. MAILIH	G ADDRESS (Street s	and Number or	Rural A	Route Number, City or To	wn, State, Zij	p Code)	
2	DR. ALBERT	NAHU	M						D BALTIMOR			8
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemet	PLACE AND DATE	other plece)			- 10	DATE 20c. L		City or Town	
	21. SIGNATURE OF FUHERAL SERVICE	LICEHSEE			22. N. SOI	AME A	EVINSO	OF FAC		INC.		
CAL CERTIFICATION	shock, or hasrt failu IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditiona, if sny, leading to immediata csuse. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions	8	O (OR AS A C	CART CONSEQUENCE O SE F CONSEQUENCE TNC E	OF): SIS OF): COF):	20	Lon	J		N AUTOPSY	24b. W	Interval Between Onset and Dei
									PERFO	RMED?	C	MALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
AN	DID TOBACCO USE COI			6. PLACE OF DE				KIAII	V DV			
ᇙᅵ	EXAMINER?	HQSPITAL:			OTHER			2.5				
XS	1 YES 2 XYO 27. MANNER OF DEATH	1) Onpatient 2		-		-	JURY AT	dence	6 ☐ Other (Specify) 28d, DESCRIBE HOW	IN HERV OV	CUBED	
ВУ РНУ	1 Netural 5 Pending 2 Accident Investigati	(Month,	Day, Your)	"	NJURY M	1 🗌	YES 2 _	NO	28d. DESCHIBE HOW	THUUNT OC	ZUMED	
ETED	3 Suicide 6 Could not 4 Homicide determine	De building	OF INJURY - g, etc. (Specif	– At home, farm y)	, stree1, facto	ry, offic	ca		261. LOCATION (Stree City or Town, Stee	t end Numbe e)	er or Rural Rou	te Number,
OMPL	one)	HYSICIAH: To the best of										nd manner ee stated
BEC	296. SIGNATURE AND TITLE OF CERT	IFIER W_	\$				29c. LICEN	18	MBER 275	29d. DA	TE SIGNED (A	fonth, Day, Year) 1 1995
5	30. NAME AND ADDRESS OF PERSON MURARILB	WHO COMPLETED CA	USE OF DEA	TH (ITEM 27) (Ty)	pe, Print) CHU F	<i>حرب</i>	4 Hos	PIT	He, 100 H	Brown	ewy (MCTO 21231

DHMH-16 Rev 1/89



MARYLAND

n/a

10g. CITIZEN OF WHAT COUNTRY? UNITED STATES

Specify:

14. RACE — American Indian, Black, White, atc.

home

LAUREL, MARYLAND

E. NORTH

1017

3. TIME OF DEATH

10d. INSIDE CITY

XX YES 2 NO

BLACK

39532

AVENUE

Approximats Interval Between

24b. WERE AUTOPSY FINDINGS

AWAILABLE PRIOR TO

OF DEATH? t TYES 2 NO

COMPLETION OF CAUSE

Onset and Death

10:49 p

REG. NO.

12,

1995

9c. COUNTY OF DEATH

2. DATE OF DEATH

OCTOBER

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

GERTRUDE

PATTERSON

6. AGE (In yrs. lest birthday,

5 SEX

7. DATE OF BIRTH (1971) 1921 219-22-4072 73 DAYS HOURS BEEN 1 M 2 XX Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE N. W ASHINGTON apt. 403 -STREET DIRECTOR 201 RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION BALTIMORE 10e. STATE MARYLAND n/a the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 21231 N. WASHINGTON STREET 201 4 hours after death. Page 6 may be retained by the hospital or attending physician. t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYPES 2 TYPES IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 XXNO Specify: t Never Married 2 X XMerried BY 3 Widowed 4 Divorced use as ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work life. Do NOT use re П 10 Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC someone else's COMPL 5 should be detached notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DANIEL COOPER LILLIAN CLARK 田田 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number 711 LIVE OAK BILOXI, DRIVE, 2 ROBINSON MABLE page pe 20e, METHOD OF DISPOSITION 20c LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, LAUREL CEM. -MARYLAND NAT.10-17 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 the in by the medical 23 PART I. Enter the placeses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List pnly one cause on each line. filled IMMEDIATE CAUSE (Final the cremation, diseese or condition RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF): event. resulting in death) bunal, COR UTERINE traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OR ATTENDING PHYSICIAN: The law requires that the death certificate be other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 the atten PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL been signed by the shows any 1 TES 2 XXO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State EXAMINER? HOSPITAL OTHER:
4 | Nursing Homa 5 | Xasidence 8 | Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28b. TIME OF INJURY 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c is marked, 1XXNatural 5 Pending 1 YES 2 NO BY DIRECTOR: After the hours after death v Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 8 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, COMPLETED 4 Homicide 28 J THE HOSPING.
TO THE FUNERAL DIRECTOR MICHIGAN TO THE FUNERAL DIRECTOR TO THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T item 29s. CERTIFIER 1 XXCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 띪 M.D AJ 4147357 0 LETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. 601 N. WOLFE STREET, BALTIMORE, MARYLAND

32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR IF UNDER 24 HRS.

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			AL SI
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5	a, I	FACI	LITY
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	CERTIFIC/	ATE OF DEATH	REG. NO.				
,	1. DECEDENT'S NAME (First, Middle, Last) Town E PUKW			2. DATE OF OEATH MONTH DA		3. TIME OF OEATH		
		yrs. last birthday) IF t	UNGER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign		
	001-38-0953 IAM20F 4	5 YRS. MON	ITHS DAYS HOURS MIN.	Month, Day, Year)	20 NE	W Hampshire		
E	9a. FACILITY NAME (If not institution, give street and number) V.A. Medical Center	9b.	Baltmore	Citu	ROLL ROLL	MORE CITY		
05	RESIDENCE OF DECEDENT		OWN OR LOCATION	0119	- Sugir	10d, INSIDE CITY		
DIRECTOR	100. STATE 100. COUNTY Baltimore Ci	ty Ba	Stimore Ci	+4		LIMITS?		
	100. STREET AND NUMBER 03 U Novella Calinget Street	ant	101. ZIP CODE	02	10g. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECENDENT OF NISPAN		or No — 14. R/	ACE — American Indian, ack, White, atc.		
BY F	Never Merried 2 Married FORCES? 1 YES IF YES, GIVE WAR OR ON		If yes, specify Cuben, Maxicar 1 YES 2 NO Specify			White		
	15. DECEDENT'S EDUCATION (Speally only highest grade completed)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during most of working	16b. KINO OF BUS	SINESS/INDUSTRY	1		
COMPLETED	Elamentary/Secondary (0-12) College (1-4 or 5+)		00 K	Rest	aura	ent		
	17. FATNER'S NAME (First, Middle, Last) Langdon Perkins		18. MOTNER'S NAI	1 0	Surname)	>		
) BE	Langam reklind	19b. MAILING ADI	DRESS (Street and Number or Rural F	oute Number, City or Tow	n, State, Zip Code)			
5	VA Kecoros			er Bal		MD		
	20a, METNOD OF DISPOSITION 1 N Burial 2 Cremation 3 Ramoval from State 4 Donation 6 Other (Specify)	PLACE AND DATE OF DI Bery, crematory or other p	place Furest Cem	10-11-95	OWING	as Mills, MI		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	2/	22. NAME AND ADDRESS OF FAC	CILITY /	•			
	July P. Carrol	/	11/2 10.100	wh an	vene	>		
	 PART I. Enter the diseases, or complications that course shock, or heart failurs. List only one cause on es IMMEDIATE CAUSE (Final 		enter the mode of dying, suci	n as cardiec or reep	ratory arrest,	Approximate interval Batween Onset and Death		
	disease pr condition Hepatic	Failure				2 WKS		
_	DUE TO (OR AS A CONSEQUENCE OF): ALCHOLIC CIVYNOSIS YEARS							
CERTIFICATION	If any, leading to immediate	CONSEQUENCE OF):						
FICA	CAUSE (Disease Dr Injury thet initiated events C. Due TO (OR AS A	CONSEQUENCE OF):						
ERT	resulting in death) LAST							
	PART II. Other eignificent conditions contributing to deeth be	at not reaulting in the	he underlying cause given in	Pert i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
DICAL	Alcohel Abuse			1 _ YES 2	V	COMPLETION OF CAUSE OF DEATN?		
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	F DEATH YES	□ NO □ UNCERTAIN	V 🔯		1 TYES 2 NO		
CIAN		28, PLACE OF DEATH (
IX	1 ☐ YES 2 NO 1 1 Inpatient 2 ☐ ER/Outp. 27. MANNER OF DEATH 28e. DATE OF INJURY	atlent 3 DOA 4 (□ Nursing Home 5 □ Residence	6 Other (Specify) 28d. DESCRIBE HOW	INTERV OCCURE			
BY Pł	1 Netural 5 Pending (Month, Dey, Year) 2 Accident Investigation	INJURY	WORK? M 1 YES 2 NO	and begoings from	WOOTT GOODILE			
	3 Sulcide 8 Could not be determined 28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, strea	nt, factory, office	28f. LOCATION (Street City or Town, State,	and Number or Rui	ral Route Number,		
LET	29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowl	edge, death occurred a	t the time, data and place, and due	to the cause(s) and ma	nner as stated.			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the best of exemination					se(s) and manner as stated.		
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER HD MD		29c, LICENSE NUI P 08 5			NED (Month, Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DE	ATM (ITEM 27) (Type, Pri	int)	/	1.00			
	GIOVIA YIM 31 A	GREEN	ST BAH	21201				
	31. DATE FILED (Mopth, Day, John) July 32 REGISTRAN'S JON	LA						

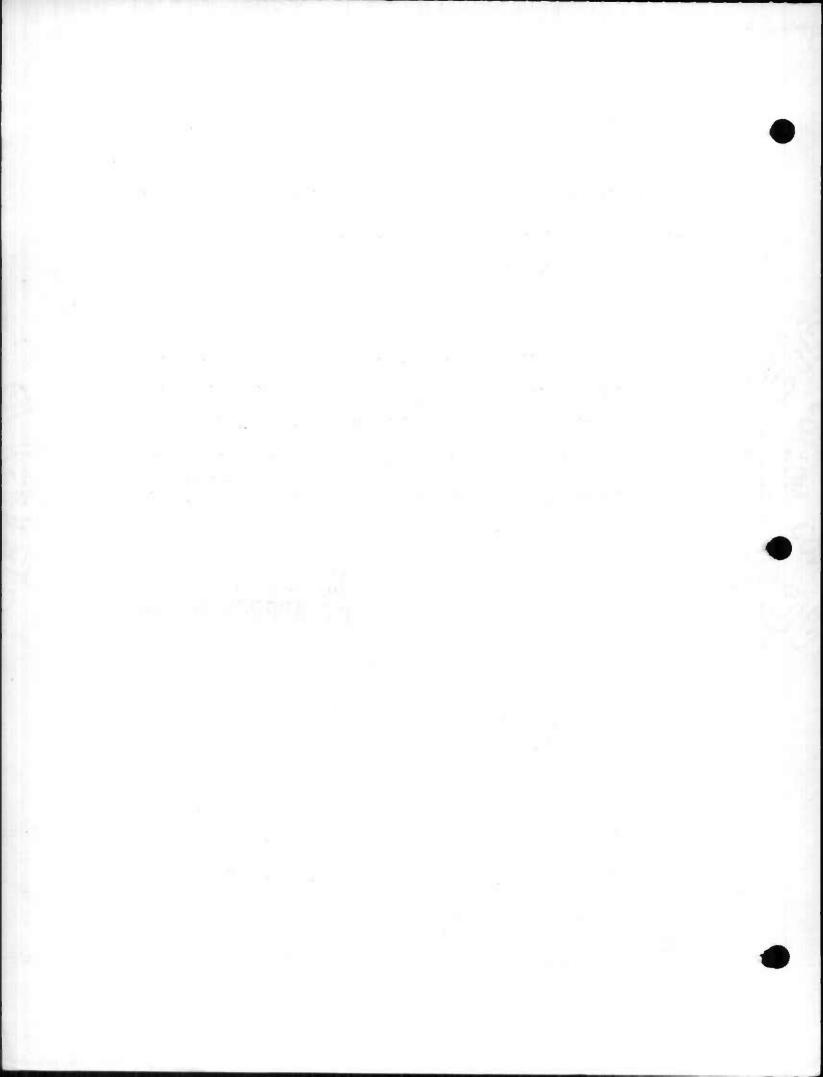


DHMH-16 Rev 1/89

HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	ECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.
THE HOSPITAL OR ATTENDING PHYSICI	TO THE FUNERAL DIRECTOR: After this cert	filed within 72 hours after death with the	IPORTANT: If item 28 is marked, o

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

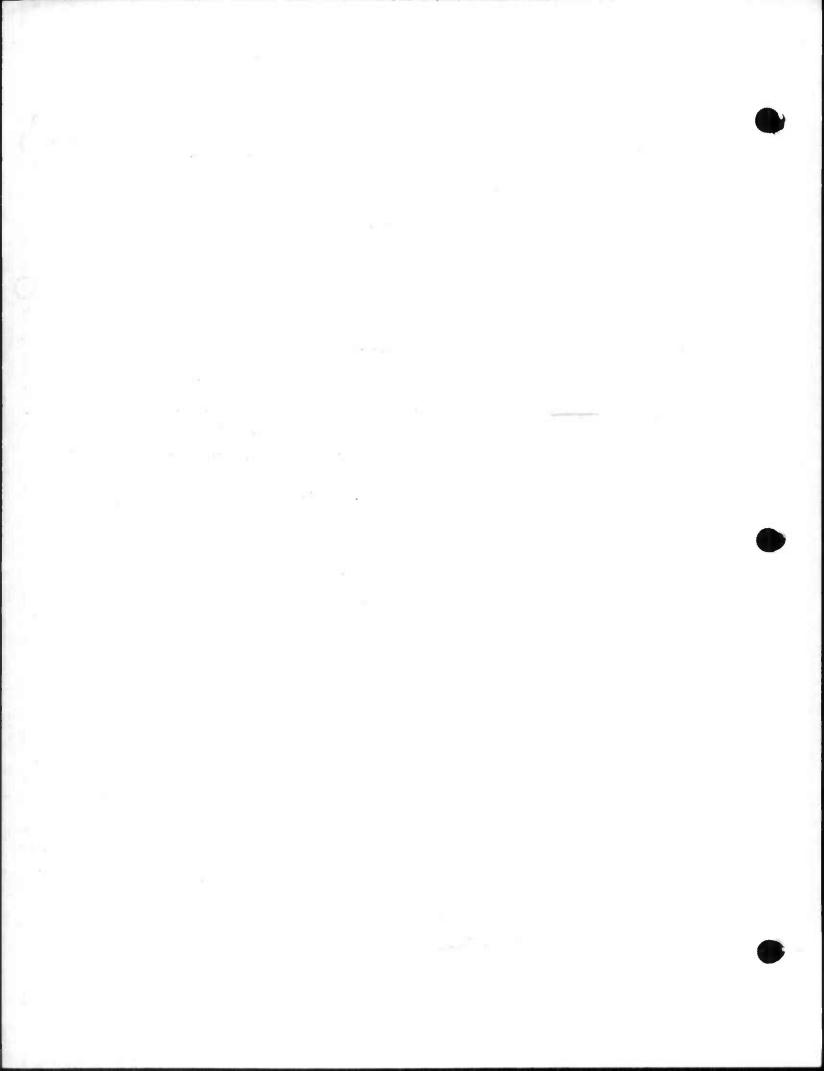
	1. DECEDENT'S NAME (First, ELIZABETH	, Middle, Last)	M	- 1	PARTE	RIDGE			2. DATE OF D	13 ^{pay}	19	95	3. TIME OF DEAT 03:05	Ам
	4. SOCIAL SECURITY NUMBER 294-05-8750	DER	5. SEX (7.4		IF UNDER 1 YEAR	IF UNDER	24 HRS. MIN.	7. DATE OF B (Month, Day	r, Year)	1	Country Oh		reign
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)	, 4		9b. CITY, TOWN	OR LOCATIO	ON OF DE			9c. COUNT	-		
DIRECTOR	University	Baltimore N/A												
EC	10a. STATE	10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION						10d. INSIDE CITY	
DIR	Maryland Baltimore				W	hite Ha	11						LIMITS?	NO
AL	100. STREET AND NUMBER					10	f. ZIP CODE				10g. CITIZ	EN OF W	HAT COUNTRY?	
ER.	2315 Hunter Mill Road						2116	1			U.	S.A		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U. FORCES? 1 YES IF YES, GIVE WAR OR DATE			YES 2 NO	DED	If yes, s		n, Mexicar	IIC ORIOIN? (S _f n, Puerto Rican ''		r No- 1	14. RACE Black Speci	American India, White, atc.	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. Elementary/Secondary (0-12) College (1-4 or 5+) 5+			(GIV	BECEDENT'S USUAL OCCUPATION Give kind of work done during most of working b. Do NOT use refined.) HOMEMAKER OWN Home									
M	17. FATHER'S NAME (First, M	firidia (ast)			TOMER	anci	18 MOTE	JED'S NA	ME (First, Middle					_
	George		rasey					Mar		immer	,			
BE	19a. INFORMANT'S NAME (Type/Print)	*	19b.	MAILING /	ADDRESS (Street	and Number	or Rural F				_		
2	Leo F. Par	tridge			21	Strabar	e Co	urt,	Balti	more,	Mar	yla	nd 21234	1
	20a. METHOD OF DISPOSIT		oval from State	20b. PLACE A	ND DATE OF	DISPOSITION (A			DATE	20c. LOCA				
	4 Donation 6 Dother	r (Specify)		St. Jo	seph	Texas	Ceme	tery	10-17	-95	Texa	s. I	Maryland	
	21. SIGNATURE OF FUNERA					22. NAME A			ciuty Funera	7 11				
	> Wal	loice.	S. Br	ohy S	4.				ad, To				204	
7	23. PART I. Enter the d	liseasea, or di neart fallure.	complications that List only one caus	caused the des e on each line.		ot enter the m	oda of dyl	ing, suci	h as cardiac	or respira	itory arre	est,	Approxim Interval 8 Onset and	etween
	disease or condition													
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Left Subdural Lematrona Subarachnoid Adays Due to (or as a consequence of):													
MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in						given in		. WAS AN AI PERFORM	IED?	24b	WERE AUTOPSY F AMALABLE PRIOR COMPLETION DF DF DEATH?	TO	
	DID TOBACCO L	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								NO				
AN	25. WAS CASE REFERRED 1					(Check only one								
PHYSICIAN:	1 X YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Ho	me 6 🗆 Re	seldenca	8 ☐ Other (Sp	ecify)				
H	27. MANNER OF DEATH		26a, DATE OF I		28b. TIME INJU		JURY AT ORK?		20d. DESCRI		JURY OCC	URED		
ВУ Р	1 Natural 5 2 Accident	Pending Investigation	10/9/	95	2:00			NO	full	devi	n 7	-8:	steps	
	2 Dulateta con	Could not be	26a. PLACE OF building, a	INJURY — At hor	ne, term, si	reel, factory, off	Ca		281, LOCATIO	N (Street and	d Number	or Rural I	Poute Number,	
TE	4 Homicide	detarmined	hon						2315	Hun	terr	mil	1 RL	
COMPLETED	29a. CERTIFIER (Check only one) 29a. CERTIFIER 1 Check only one) 29a. CERTIFIER 1 Check only one) 29a. CERTIFIER 1 Check only one) 20a. CERTIFIER													
	296. SIGNATURE AND TITLE	E OF CERTIFIE	R				29c. LIC	ENSE NUI	MBER		29d. DATE	SIGNE	(Month, Day, Year	
O BE	Media	1-	- 1 u	~~~	1		IAF	10	371	2	1 KC)/1	3195	
5	30 NAME AND ADDRESS O	F PERSON W	O COMPLETED CAUS	E OF DEATH (ITEM	1 27 (Type,	Print)						1		
	251		9 /	OM	M	7								
	31. DATE FILED (Month, Day, OCT 1 719)		32. REGISTRAF	Reveall	,									
													DMMM	6 Day 15



31. DATE FILED (Month, Day, Year) OCT1 71995

32. REGISTRAR'S SIGNATURE

Item# 19.a.G-film 728 per F.H 10/25/95 P.C.
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH 2. DATE OF DEATH 3. TIME OF DEATH PARDOE OCTOBER 10-40 PM 4. SOCIAL SECURITY NUMBER S. SEX 7. DATE OF BIRTH (Month, Day, Year) Sept. 24, 1921 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTNPLACE (State or Foreig DAYS 217 16 3550 1 M 2 X F Maryland Should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harbor Hospital Center DIRECTOR Baltimore N/A Pages 1, 2, 3 RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Maryland **Baltimore** 1 X YES 2 | NO and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, burial, cremation, or removal. 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2723 Hollins Ferry Road U.S.A. 21230 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Msxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 X NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker 10th Own Home 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Lawrence Meyers Kweder Anne 76 BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William Perdoe Pardoe 2723 Hollins Ferry Road Baltimore, Maryland 21230 9 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 1 X Burist 2 Cremation 3 Ren 4 Donation 8 Other (Specify) Loudon Park Cemetery 10/18 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY George J. Gonce Funeral Home P.A. vettere 4001 Ritchie Hwy. Baltimore, Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death event, the RYPTOGENIC COMPLICATED CIRRHOSIS disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): LEURAL EFFUSION SIDED traumatic CERTIFICATION Sequentially list conditions, 5 DUE TO (OR AS A CONSEQUENCE OF): attending physician a If any, leading to immediate ORTAL HYPERTENSION cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST DEPENDENT DIABETES MELLITUS 6 signed by the atter Health and Mental PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has b. Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 Vinpatient 2 ER/Outpatient 3 DOA certificate In the State 1 YES 2 NO OR ATTENDING PHYSICIAN: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) this c 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED DIRECTOR: A 4 Nomicide 500 29s. CERTIFIER riedge, death occurred at the time, data and placs, and due to the cause(s) and manner as stated. HOSPITAL FUNERAL C = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II stion, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE · JOSEPH 2441614 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JOSEPH ANSON 3001 - HARBOR HOSPITAL CENTER MD



10:50

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

WHITE

1 X YES 2 NO

Approximata

interval Bety

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO

OF DEATHS 1 TYES 2 NO

COMPLETION OF CAUSE

Onsetuand Death

FLORIDA

N/A

USA

Specify

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1995

BALTIMORE, MARYLAND 21215-0020

funeral director, page 5 should be detached for use as the bunial-transit

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

hours after death. Page 6 may be retained by the hospital or attending physician. i signed by the attending physician and completely filled in by the i Health and Mental Hygiene prior to burial, cremation, or removal. requires that the death certificate be executed within has been s Dept. of H HOSPITAL OR ATTENDING PHYSICIAN: The law this certificate h with the State [DIRECTOR: After the hours after death v TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH THOMAS OCTOBER 4, PAIGE A. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 1 - 28 - 27 IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 234-62-4448 1 X XM 2 | F 68 HOURS YRS 9a. FACILITY NAME (If not institution, give street and number) 96 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10a. STATE 10h COUNTY 10c. CITY, TOWH OR LOCATION MARYLAND N/A BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 113 N. EAST AVENUE 21224 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Pu 1 YES 2 NO Specify: Never Married 2 Married BY 3 Widowed 4 Divorced ARMY 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 1+ Τ. ٧. TECH. SELF EMPLOYED 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) UNKNOWN LINKNOWN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. ARLENE DePASQUALE 3402 CLIFTMONT AVE. BALTO. MD. 21213 20e. METHOD OF DISPOSITION
1 A Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State TAKE AWN "CEMETERY ☐ Donation 5 ☐ Other (Specify) 10 - 7BALTO. MD. SIGNATURE OF FUNERAL-SERVICE LICENSEE CACZOROWSKI FUNERAL HOME 525 FLEET ST. BALTO. MD. 21224 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory errest, shock, or heart feliure. List only one ceuse on each line. **IMMEDIATE CAUSE (Fine)** diseese or condition Ma Cerebra resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) AVOMDO CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or injury that initiated events atherosclerosis resuiting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH

SPITAL

25. WAS CASE REFERRED TO MEDICAL

1 TYES 2 NO

	The second of the second of the second	- many a m van	raing mome a LL residence	n T DOM: (Sheck)	
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b, TIME OF INJURY M	28c. INJURY AT WORK?	28d, DESCRIBE HOW II	JURY OCCURED
3 Suicide & Could not be determined	28s. PLACE OF INJURY — At hor building, etc. (Specify)	me, tarm, street, fac	nory, office	28f. LOCATION (Street a City or Town, State)	end Number or Runel Route Numbec
290. CERTIFIER Check only one) 2 MEDICAL EXAMINER: 1 290 SIGNATURE AND TITLE OF CENTIFIER			time, date and piece, and du- opinion, death occured at the	time, date and place, an	order as stated. d due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)
M. HAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (ITEM	1 27) (Type Pridt)	1		700000
John A	Bellan, Mi	0 Jo	has Hopkin	s Hospital	Baltimore Maryla
OCT 1 (1995)	31 REGISTRAR'S GNATURE		7		
					DHIM 16 Page

YES NO

26. PLACE OF DEATH (C

ent 3 DOA

UNCERTAIN

5 - Residence 6 - Other (Specify)

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

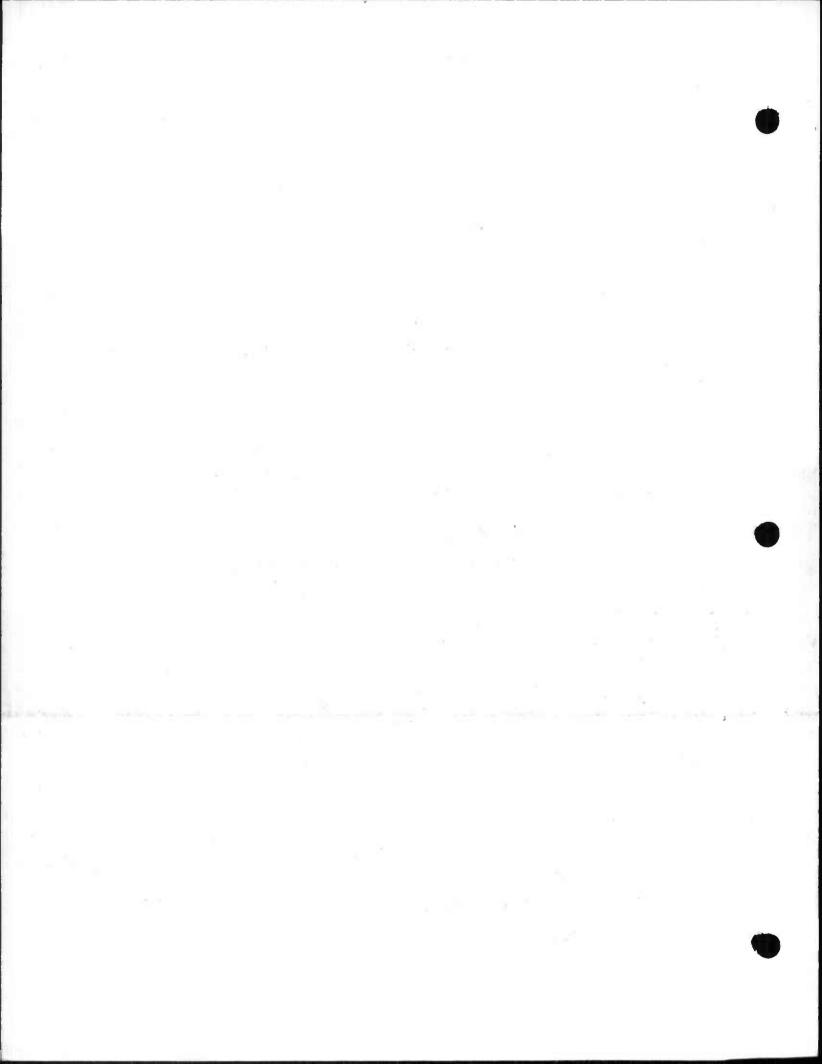
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital in rationaling physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.

	1. DECEDENT'S NAME (Firs	t, Middle, Last)									OF DEATH			3. TIME OF DEATH
	Soebagjo Prodjohabsoro					O OC				Oct 11 1995 3:00			3:00 A M	
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER			R 24 HRS.	7. DATE C	P BIRTH Day, Year)		8. BIRTHP	LACE (State or Foreign
1		8a. FACILITY NAME (If not institution, give street and number)					DAYS	HOURS OR LOCAT	MIN.	Nov	Nov 24 1935 Indonesia			
Œ	THE RESERVE AND ADDRESS OF THE PARTY OF THE					100					179.0	1000		
DIRECTOR	Holy Cro	CEDENT	Spitai			21	Tve	r Sj	or TI	19		MO	nitgo	omery
Ë	10a, STATE	10b. COUNTY	r		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
ā	Maryland		ntgomer	У	Che	evy								1 K YES 2 □ NO
FUNERAL	10e. STREET AND NUMBER						10	. ZIP COD	_					IAT COUNTRY?
N.	8606 Grub	b Roa		T 51155 111 11 6 1 6 1		1			815				USA	
BY FL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced				O		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:					14. RACE Black, Specify	- American Indian, White, atc. : White	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (((CEDENT'S	S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY work done during most of working use retired.								
COMPLETED	Elementery/Secondary (College (1-4 or 5			se retired.)								
MP			4	e A Can	11.	6-64							ı Em	bassy
	17. FATHER'S NAME (First, A	fiddle, Last)						18. MOT	HER'S NA	ME (First, M	iddle, Maiden	Surname)		
BE	Muljono 19a. INFORMANT'S NAME (Type/Print)		100	MAII INC	1000000	0 (0)		kmir					
2			,						_	Route Numbe	or, City or Tou	m, State, Zip	Code)	
	Titiek Pi	TON		20b. PLACE A		as OF DISPOS			()a-:	DATE	200 10	CATION —	Other day Years	- Paul
ì	1 X Burlel 2 Crematic		oval from State	cametery, cren	natory or o	ther place)			Cor					aryland
	21. SIGNATURE OF FUNERA	L SERVICE LIE	ENGER	T GEOT	8 E	22.	NAME A	ID ADDRE	SS OF FA	CILITY		ADO FORTH		aryland
	W Su	4	Ni	6.16						on Fu				
	35. PART I. Enter the d	liseases, or o	complications the	t caused the dea	oth. Do i	not enter	the mo	s C	hur	ch. Y	/irgi	nia	2:	2046
	/ snock, or h	eart fallure.	List only one cau	se on each line.		not onto	tito mo	ue or uy	mg, auc	al es carul	ac or reap	metory arr	eat,	Approximata interval Between
	IMMEDIATE CAUSE (Fig	nai	LIVE	RF	414	URE	=							Onset and Death
	resulting in death)		8.	•										6 chs
z	DUE TO (OR AS A CONSEQUENCE OF): METASTATIC ADENOCARCINOMA 18MJS													
	Sequentially list condit if any, leading to imme	diate		(OR AS A CONSEO										
CERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or Inju		C	/OD 40 4 0011050										
	that initiated events resulting in death) LAS	т	DUE 10	(OR AS A CONSEC	UENCE O	F):								
E			d											
MEDICAL	PART II. Other algolitical	nt condition	s contributing to	death but not re	aulting	In the ur	nderiyin	cause	given in	Part i.	24a. WAS AN			VERE AUTOPSY FINDINGS
2											1 TES 2			COMPLETION OF CAUSE OF DEATH?
M										(YES 2 NO
Ž	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	N 🗆				
S	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	26. PLACE	OF DEA	OTHER								
PHYSICIAN:	1 YES 2 NO		1 Inpatient 2			4 🗆 Nun	sing Hom	7.7	sidence	8 🗆 Other				
	1 Netural 5	Pending	28a. DATE OF (Month, D		28b. TIM INJ	URY M		RK?	7	28d. DESC	RIBE HOW I	NJURY OCC	URED	
BY	2 Sulplda	Investigation	28a, PLACE O	F INJURY — At hon	ne ferm	ttreet fect	1 🔲 Y		NO	201 1 0001	MON (Steen of	and Nove have		
COMPLETED		Could not be determined	building,	atc. (Specify)		otrout, toct	ory, orne.			City or	TION (Street in Town, State)	ind Number	or Hural Floi	ute Number,
7	29a. CERTIFIER (Check only	TIFYING PHYSI	CIAN: To the best of	my knowledge, dae	th occurr	ed at the t	lme, data	and place	, and due	fo the caus	e(a) and mai	ner as atate	ıd.	
S	one) 2 MED	ICAL EXAMINE	R: On the basis of a)	amination and/or in	veatigatio	n, In my o	pinion, d	eath occur	red at the	tima, data a	nd place, an	d dua to the	cause(a)	and manner as stated.
	29b. SIGNATURE AND THE								ENSE NUN					Aonth, Day, Year)
200	a	reix	4nn				İ	D.	292	294		1	0/11	195
2	30. NAME AND ADDRESS OF													
			cticur,			CEN	5120	Tan	/	An	208	75		
	31. DATE FILED (Month, Day,		EGISTRA	R'S SIGNATURE	.11									
	QCT 17	1	frank will	ANGEL HERMON	all a									



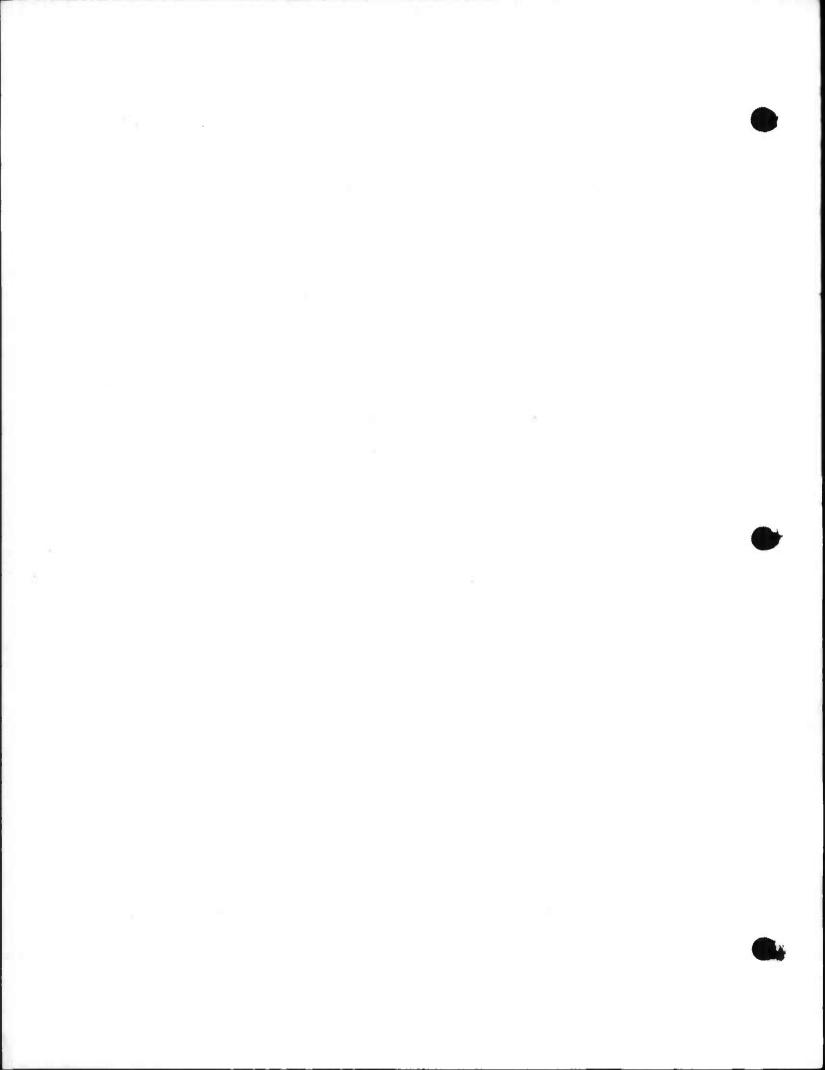
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. ROX 68760

DIVISION OF VITAL NECONDS, F.O. BOX 60700.	DALLIMORE, MARTLAND ZIZIS-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	mours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit, Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	IAIE UF MAKYL			OF DEAT		REG. NO	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
	CHARLE		NTHAL				OCTOBER I	2, 1	995"	1700 •
	4. SOCIAL SECURITY NUMBER 5. S		(In yrs. lest birthday)	MONTHS D	AR IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1	8. BIRTHE Country	PLACE (State or Foreign
	552-42-4332 19a. FACILITY NAME (If not institution, give street a							8-16-33 California		
OR	2 St. Louis Ave.	#9			AN CIT		ii H	9c. COUNTY OF DEATH WORCESTER		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. C/1	Y, TOWN OR L	OCATION					10d. INSIDE CITY
E	MD. Worces	TER	00	EAN CI	TY					LIMITS?
AL	10e. STREET AND NUMBER	""			10f. ZIP CODI			t0g. CIT		HAT COUNTRY?
FUNERAL	2 St. Louis Ave.				2184			US	A	
BY FUI	1 77 Nover Married 2 Married	WAS DECEOENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If ye	DECENDENT Cos, specify Cube YES 2 X NO	n, Mexican,	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No—	14. RACE Black, Specify	— American Indian, White, atc.
	15. DECEDENT'S EDUCATIO	N	18a. DECEDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	SINESS/IN	MISTRY	White
COMPLETED	(Specify only highest grade comp	leted)	(Give kind of life. Do NOT u	work done durin	g most of working	ng	ISS. KIND OF BOX	JINE SO/IIVI	Josimi	
MPL	6th Grade		Choco	late M	aker		Candy	Comr	anv	
00	17. FATHER'S NAME (First, Middle, Last)				-		E (First, Middle, Malden	Surneme)	1	
BE	John Edward Rosent	hal					Geneviev			S
ဥ	Norma Downs (Niece)						ute Number, City or Tow			01001
	20a. METHOD OF DISPOSITION	201	PLACE AND DATE			ie, B	altimore,		City or Ton	
	1 N Buriel 2 Cremetion 3 Removal 1 4 Donation 5 Other (Specify)	rom State	notoni oromotoni or o	shee slees I		10/	18/95 Ba			
	21. SIGNATURE OF FUNERAL RERVICE LICENSE	E //	JOE HOLY	22. NAR	E ANO AGORES	SS OF FACI	LITY	r c ruic	ne.m	arviand
	1 / Spring 1	Te:					eral Home ane, Balt:	imore	ма	. 21213
	23. PART i. Enter the diseases, or pomp	lications that ceuse	d the deeth. Do	not enter the	mode of dyl	ing, such	ea cardiec or reepi	retory an	reat,	Approximate
	ehock, or heart failure. List of iMMEDIATE CAUSE (Final	only one cause on e	ech line.							Interval Between Onset and Death
	disease or condition resulting in deeth)	MALNU	RITION	/						SECTOL POWE
		DUE TO (OR AS	CONSEQUENCE O	F):						
NO O	Sequentielly list conditions, b.	ETHANO	CONSEQUENCE O	D:						ENSCAL YIS
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	502 10 (611 145)	CONSESSENCE O	·).						
Ē	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE O	F):						
E	resulting in death) LAST									
	PART II. Other aignificent conditions con	ntributing to deeth b	out not recuiting	in the under	lying cause o	lven in P	ert i. 24s, WAS AN	AUTOPSY	240.	WERE AUTOPSY FINDINGS
ICAL	199						PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI							_			OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTRIBU	TE TO CAUSE C	F DEATH Y	S NC	□ UNC	ERTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	26. PLACE OF DEA	TH (Check only	one)					
IXSI	1 YES 2 NO 1	Inpatient 2 - ER/Outp		4 - Nursing			Other (Specify)			
ву рн	27. MANNER OF DEATH 1 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	JURY	INJURY AT WORK?		28d. DESCRIBE HOW II	NJURY OC	CUREO	
<u> </u>	3 Suicida a Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory,	office		2af. LOCATION (Street a City or Town, State)	and Number	or Aural Ro	oute Number,
LET	290. CERTIFIER (Check only	To the best of my know	ledge death occur	ad at the time	date and place	and due to	the equation and more			-
COMPL	(Check only one) 2 M MEDICAL EXAMINER: On									end manner as stated.
ECC	290. SIGNATURE AND TITLE OF CERTIFIER	20 0 0				NSE NUMB				Month, Day, Year)
00	Dorothy C. Hote	watt	1.8.							
임	36. NAME AND ANDRESS OF PERSON WHO CON	//		Print)		_	H Swow	./		
	JUKOTHY C, I	TOLZWOX		203	SNOT	W ST.	Swow	HILL	, No	. 21863
	31. DATE FILEO (Month, Day, Year) OCT 1 7 1995	32. REGISTRAR'S SIGN	ATURE							
	0017 (1992)	distant.	20							



ALTIMORE, MARYLAND 21215-	AN. The last fortified that darth cartificate he executed within the house dark Date Come he seem to seem to the tracks.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	certificate he executed with
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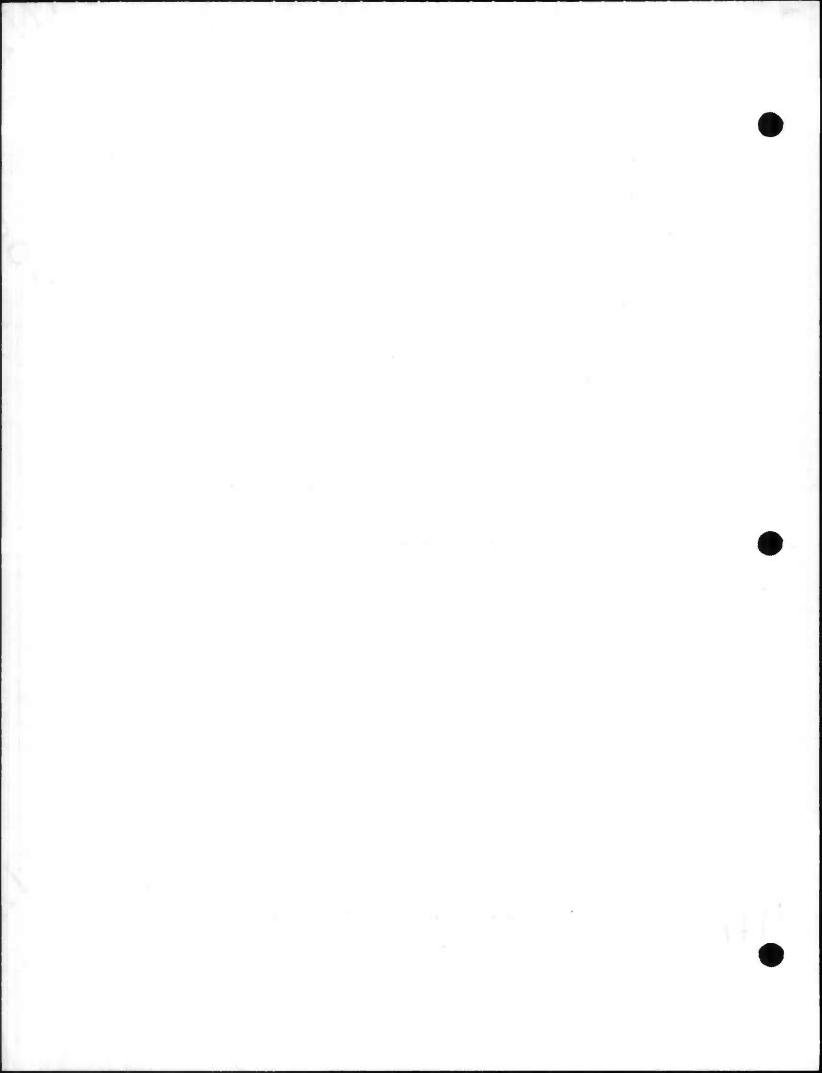
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMEN	T OF HEALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AM MEAN	3. TIME OF DEATH	
	Wyatt T. Reynolds				October 1	5, 1995	6:35 P M	
		SEX 6. AGE (In yrs. las	YRS. MONTHS	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	MAR. 9,1898	VII	PLACE (State or Foreign	
TOR	2035 E. Lanvale Str		9b. Cn	y, town or Location of Baltimor		9c. COUNTY OF C		
DIRECTOR	10e. STATE 10b. COUNTY	n/a 10c. CITY, TOWN OR LOCATION BALTI			RE 10d. INSIDE CITY LIMITS?			
FUNERAL	10%. STREET AND NUMBER 2035 E. LANVALE	STREET		101. ZIP CODE 21213	3	109. CITIZEN OF WHAT COUNTRY? UNITED STATES		
BY	11. MARITAL STATUS 12. 1	. WAS DECEDENT EVER IN U.S. AR FORCES? 1 XX ES 2 N IF YES, CIVE WAR OR DATES 18 7 2 19	MED 13	. WAS DECENDENT OF HISP If yes, specify Cuban, Maxi 1 YES 2 XXNO Specify	Blac	E — American Indian, k, Whita, etc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com Elementary/Secondary (0-12) Company (0-12) Company (0-12) Company (0-12) Company (0-12)	CEGENT'S USUAL IVE kind of work done Do NOT use retired.	during most of working	YL AND				
	17. FATHER'S NAME (First, Middle, Last) REV. ELISHA H.	REYNOLDS		16. MOTHER'S N	NAME (First, Middle, Maiden NORA ERKHAR	WESTERN MARYLAND Middle, Maiden Sumame) ERKHART REYNOLDS		
TO BE	196. INFORMANT'S NAME (Type/Print) AUSTIN WALKER	194	2035 E.	SS (Street and Number or Aura LANVALE S	TREET, balt	imore, M	21213	
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removat 4 Donation 5 Other (Specify)	from State 20b. PLACE A complexy, cre	MODATE OF DISPO	SITION (Name of CEMETERY		CATION — CITY OF TO ALTIMORE		
	21. SIGNATURE OF FUNEBAD SERVICE LICENS	K. Amo	22	WM. C. MARCI		E. NORTI	H A VENUE	
	23. PART I. Enter the diseases, or com- shock, or heart failure. List	plications that caused the detonly one cause on each line	eth. Do not ente	r tha mode of dying, au	ich aa cardiac or reapi	ratory arrest,	Approximata	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Coronary Art	ery Dise	ease			Interval Between Onset and Death	
ATION	Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING							
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST							
AL	PART II. Other aignificant conditions co	ontributing to deeth but not n	eaulting in the u	nderlying ceuse givan i	n Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
PHYSICIAN: MEDIC					1 🗆 YES 2		COMPLETION OF CAUSE DF DEATH?	
N.	DID TOBACCO USE CONTRIB				IN 🗆			
SICI		OSPITAL:	E OF OEATH (Check	R:				
	27. MANNER OF DEATH 1 X Netural 5 Pending	Inpetient 2 ER/Outpetlant 3 28e. DATE OF INJURY (Month, Dey, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	6 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCUREO		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	26s. PLACE OF INJURY — At hor building, etc. (Specify)	me, term, straet, te	1 YES 2 NO	28t, LOCATION (Street a City or Town, State)	and Number or Rurel F	Route Number,	
COMPLETED		N: To the best of my knowledge, dea						
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER	in the basis of examination and/or is	nvestigation, tn my	29c. LICENSE NI	UMBER	29d. DATE SIGNED		
10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITEL	27) (Type Print)	215	450.	10/10	6195	
	Mohamed Al-Ibrahim,	, M.D., 10 N. G		reet. Balti	more MD 2	1201		
	OCT 1 71995 Juli	32 REGISTRAR'S SIGNATURE		27,34,61				
	-							



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	OCTITION E OF BLATTI NEG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH
	CATHERINE REAVES NOT 14 95 8:40 Ri
	CIFI IFFICING ICERVES 104, 14 43 8.40"
	4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign
	Self
	Dept 29, 1727, 114
	9a. FACILITY NAME (If not institution, give street and number) 9b. CFT TOWN OR LOCATION OF DEATH 9c. COUNTY OF, DEATH
E .	1200 Decours Massitul Balto
DIRECTOR	RESIDENCE OF DECEDENT
	AT STATE . LONG COUNTY
<u>~</u>	106. CITY, TOWN OR LOCATION 106. CITY LIMITS?
	1 M res 2 No
	10s, STREET AND NUMBER 10st, CITIZEN OF WHAT COUNTRY?
2	2451 10 10 11
	NTUG ITANTICE TO NO WISTE
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14. RACE — American Indian,
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc.
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:
	Black
0	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY
ш	(Specify only highest grade completed) (Give kind of work done during most of working file. Do NOT use retired.)
4	12th NA Never-Worked NA
Ξ	
COMPLET	17. FATHERIS NAME (First, Middle, Malten Surrame)
Ш	Mille K. Mayes Carrie Vactor
<u> </u>	18th, INFORMANT'S NAME-(Type/Print) 19th, MAILING ADDRESS, (Street and Number or Rural Route Number City or Trunch Titol.)
2	
	Cynthia 11/2 Tail 2406 Monticello Kal Bulto And 21216
	20a, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of OATE 20c, LBCATION — City or Town, State
	1 b Burial 2 Cremation 3 Removel from State Compatent organization of the place 1504
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	21. SIGNATURE OF PLACE LICENSEE 22. NAME AND ADDRESS OF FACILITY
	Man f. H-Wes
	Deput D. Acolt 4300 Wabash Ave
	22 DADY I Date the discharge of the New York and the New
	abock, or heart feilure. List only one cause on each line. Approximata interval Between
	IMMEDIATE CALICE (Final
	disease or condition resulting in death) a. Cardiac Fallure (Shock)
	OUE TO (OR AS A CONSEQUENCE OF):
z	
0	Sequentially list conditions, PUE TO (OR AS A CONSEQUENCE OF):
4	If any, leading to immediate cause. Enter UNDERLYING
일	CAUSE (Disease or injury & c.
<u> </u>	that initiated events DUE TO (DR AS A CONSEQUENCE OF):
	resulting in death) LAST
CERTIFICATION	
	d,
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¥	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO AMAILABLE PRIOR TO
DICAL	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPORTING AMAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PERFORMED? 1 D ES 2 D NO OF DEATH?
Σ	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPORTING AMAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PERFORMED? 1 D ES 2 D NO OF DEATH?
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Σ	PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. PERFORMED? 1 D ES 2 NO 24a. WAS AN AUTOPSY FINDINGS AMAIJABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
Σ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contributing in the underlying cause given in Part I. Part II. Other significant conditions contribution cont
Σ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 VES 2 NO 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) There: 1 VES 2 NO 27. MANNERI OF DEATH 28e. DATE OF INJURY 29b. TIME OF 28e. INJURY AT 28d. DESCRIBE MOW IN BURY OCCURRED
PHYSICIAN: M	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 VES 2 NO 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? 1 Netural 5 Pending
Σ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 VES 2 NO 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNERI OF DEATH 1 Netural 5 Pending Investigation 28c. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 VES 2 NO 28d. DESCRIBE HOW INJURY OCCURED
BY PHYSICIAN: M	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributions contribution in Part I. PART II. Other significant conditions contributions contributions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part I. PART II. Other significant conditions contribution in Part II. PART II. Other significant conditions contribution in Part II. PART II. Other significant conditions contribution in Part II. Other significant conditions contribution in Part II. Other significant conditions contribution in Part II. Other significant conditions contribution in Part II. Other significant conditions contribution in Part II. Other significant conditions
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BY PHYSICIAN: M	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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E COMPLETED BY PHYSICIAN: M	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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ITEM:	1.	PER	F.H.	FILM	G-728	10/17/95	t.
4 1						,,	

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	BERNADETT			ICATE O	F DEATH	2. DATE	REG. NO		3, 1	IME OF DEATH
	Permotette						MONTH - 10			YEAR	1015
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	\rightarrow	IF UNDER 1 YEAR		. 7. DATE	OF BIRTH th, Day, Year)		8. BIRTHPLAC	E (State or Foreign
	215 30 5143	1 🗌 M 2 🔀 F	61	YRS.	MONTHS DAY		Jan	. 19,		Mary	
ОВ	90. FACILITY NAME (If not institution, give St. Agnes Hos				96. CITY, TOW	n or location of NOTE	DEATH		9c. COUN	TY OF DEATH	
ECT	RESIDENCE OF DECEDENT									104	INSIDE CITY
DIRE	Maryland N/				ltimor						LIMITS?
FUNERAL	100. STREET AND NUMBER 3617 Brooklyn	Avenue				101. ZIP CODE 21225				S.A.	COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2		If yes,	DECENDENT OF HISI apocity Cuban, Max (ES 2 17) NO Spi	ican, Puerto		s or No-	Black, Wi Specify:	merican Indian, ille, alc.
G	15. OECEDENT'S ED (Specify only highest grad				USUAL OCCUPA work done during		16	b. KIND OF BU	SINESS/INDI		1111100
PLET	Elementary/Secondary (0-12) 12th	College (1-4 or 5+) A	le. Do NOT u	se retired.) Manage			Human Development			t
COMPL	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S		IAME (First, Middle, Meiden Surname)			
BE (1	a1kowsk				artha					
6	19a. INFORMANT'S NAME (Type/Print) Donald Rutter					RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOKLYN Avenue Baltimore, Maryland 2					nd 2122!
	20a. METHOD OF DISPOSITION	- 265-	20b. PLAC	PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State							
	1 Buriel 2 (**XCremation 3 Removal from State Cametery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/17 Baltimore, Metro Crematory or other place) Metro Crematory 10 10/17 Baltimore, Metro Crematory 10/17										ryland
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE 1 Room	in our SI	le;	Geor	and address of ge J. Go Ritchie	nce F				21225
Z	immediate cause (Final disease or condition resulting in death) a										21/2 year
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL (PART II. Other algorificent condition	ona contributing to	deeth but no	not resulting in the underlying ceuse given in				1 YES 2 MNO		COL	RE AUTOPSY FINDI ILABLE PRIOR TO MPLETION OF CAUS DEATH?
. M	DID TOBACCO USE CON	ITRIBUTE TO CA	USE OF DE	ATH Y	ES NO	UNCERT	AIN 🗆			1	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DNO	HOSPITAL:			OTHER:	ne)		(Frank)			
PHY	27. MANNER OF DEATH 1 Astural 5 Pending	28a. DATE OF (Month, D	INJURY	28b. Til	ME OF 26c.	INJURY AT WORK?		ESCRIBE HOW	INJURY OCC	CURED	
ВУ	2 Accident Investigation 3 Suicide 8 Could not b 4 Homicide determined	28a. PLACE O	28a. PLACE OF INJURY — At home, farm, street, factory, offi building, etc. (Specify)			YES 2 NO		CATION (Street y or Town, State		or Rural Route	Number,
ED	29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and maintain manner.										
ED	(Check only					n, death occured at	the time, de	te and place, a	nd due to the	e ceuse(a) an	d manner as state
BE COMPLETED	(Check only 1 DENTIFYING PHY ONE) 2 DMEDICAL EXAMI 29b. SIGNATURE AND TITLE OF CERTIFY OWN M	INER: On the basis of a	xamination end/	or Investigati	on, in my opinio	29c. LICENSE D 408	NUMBER	te and place, a	29d. DATE	E SIGNED (Mo	
COMPLETED	(Check only 2 MEDICAL EXAMI) 29b. SIGNATURE AND TITLE OF CERTIF OVA 30. NAME AND ADDRESS OF PERSON V	NER: On the basis of a: FIER WID WHO COMPLETED CAUS TAU ATUU	xamination end/	TEM 27) (Typ	e. Print)	29c. LICENSE 1	NUMBER 50		29d. DATE	E SIGNED (MO	nth, Day, Year) 16, 149

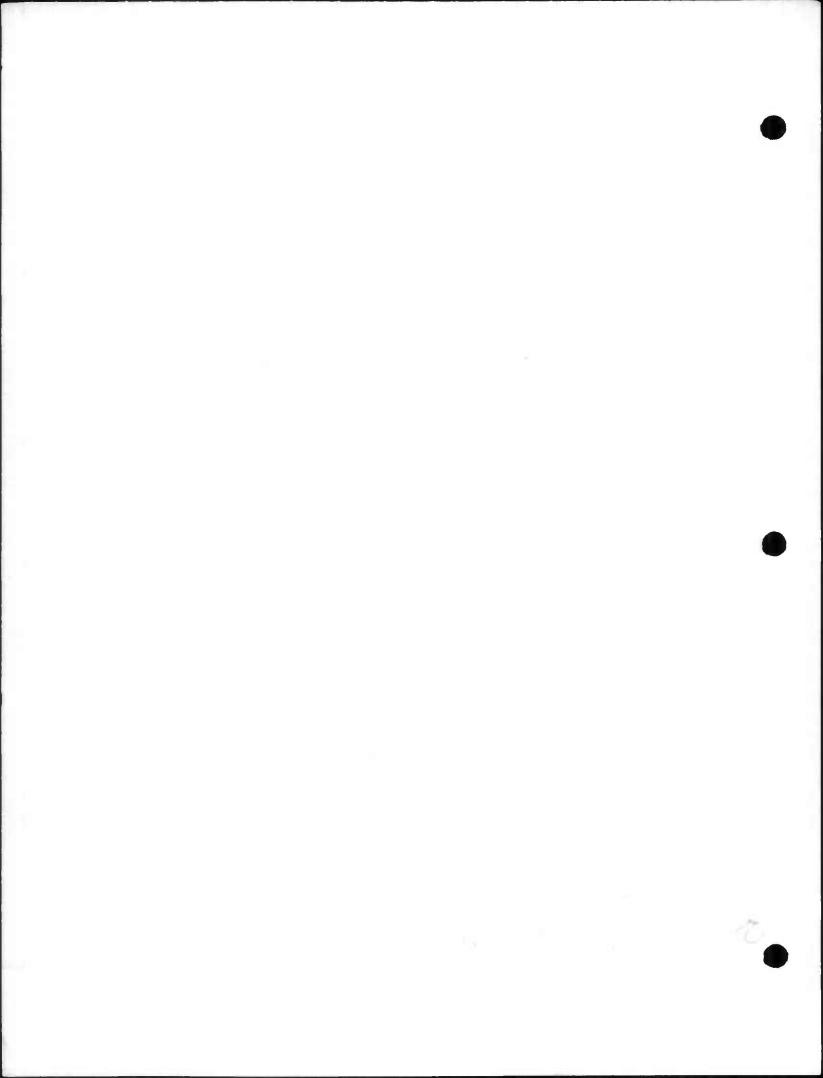
5 may be retained by the hospital or attending physician. tor, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

after death. Page 6 may be retained by the hosp	age 5 should be detached	be notified at once.
4 hours after death. Page 6 mz	illed in by the funeral director, n, or removal,	e medical examiner must
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
PHYSICIAN: The law requires that	this certificate has been signed by with the State Dept. of Health and	arked, or item 23 shows any
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death	IMPORTANT: If Item 28 is ma

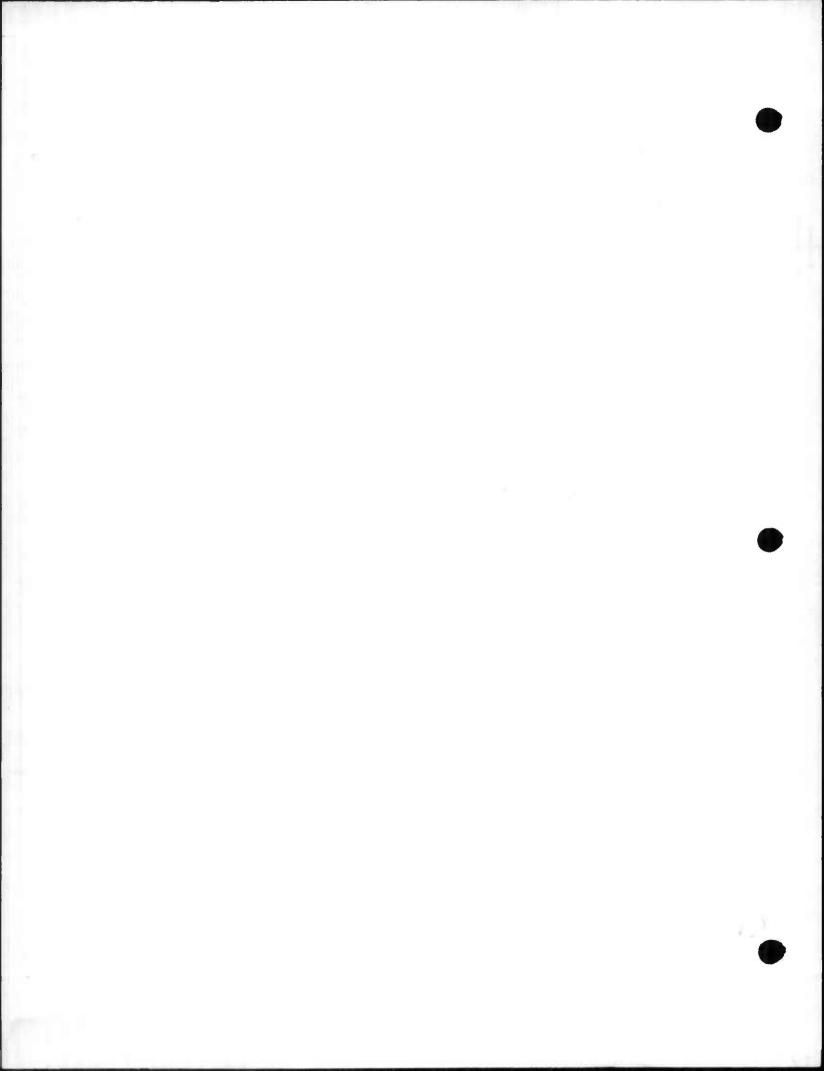
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M	ENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MAI	RYLANI	D / DEPAI	RTMEN	T OF H	IEALTH AND DEATH	MENT	AL HYGIEN			
ŝ	1. OECEDENT'S NAME (First, Middle, Last)						DEMIN		E OF DEATH			3. TIME OF DEATH
14	Eleanor V	Villiams	Ro	ssmaı	nn			1 (3	95	4:25 AM
- 8	4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In yrs. lest birthday) # UN				YEAR IF UNDER 24 HRS. 7. DATE OF				0 0	PLACE (State or Foreign
- 1	214-34-3996	1 🗆 M 2 💢 F	88	YRS.	MONTHS	DAYS	HOURS MIN.		t. 20.	190		rginia
œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DI											
DIRECTOR	RESIDENCE OF DECEDENT	HOME			00	скез	ysville				Bal	timore
E	10a. STATE 10b. COUN	• •	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY
	Maryland Bal	timore			Cock	teys	ville					LIMITS?
₹¥	10e. STREET AND NUMBER	1 0: 1				101	. ZIP CODE	-		10g. CITIZ		VHAT COUNTRY?
FUNERAL	300 Internation						2103	0			U.S	S.A.
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EN	YES 2	☑ NO	13.	WAS DEC	ENDENT OF HISPA	ANIC ORIG	IN? (Specify Ye Rican, etc.)	a or No-	14. RACE Black	E — American Indian, k, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	21			2 X NO Spec		, ,		Speci	White
	16, DECEDENT'S ED		16a	. DECEDENT'S	USUAL O	CCUPATIO	ON	16	ib. KIND OF BU	SINESS/INDI	USTRY	WILCE
ᆸ	(Specify only highest grad	College (1-4 or 5+)		(Give kind of life. Do NOT u	se retired.)							
MP		4 years	A	dminis	strat	ive	Assista	nt S	tate R	oads (Comm	ission
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	7 - 7 7 .					18. MOTHER'S N					
BE	Haswell Roger	Williams							e Hero			
2	19a. INFORMANT'S NAME (Type/Print)	TT					nd Number or Rural					350 01000
	Maryland Masonic	Homes										MD 21030
	20g. METHOD OF DISPOSITION 1 A Buriel 2 Cremetion 3 Ref	noval from State	20b. PLA cemetery.	CEAND DATE	of DISPOS	SITION (Na	me of	1		CATION — C		
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	WO	odrawi			J	10/			n, r	laryland
	DO 10						nell-Wie					
	23. PART I. Enter the diseases, or	errane			(5500	York Ro	ad	Baltim	ore,	Mary	land 21212
CERTIFICATION	shock, or haart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentlelity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL C	PART II. Other significant condition	na contributing to des	ath but no	ot resulting	in the ur	nderlying	g ceuse given in	Part I.	24s. WAS AN PERFOI 1 YES	RMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF DEATH (C	heck only o	one)			
₹SI	1 TYES 2 NO	1 Inpatient 2 ER		t 3 □ DOA	4 Nur		e 5 ☐ Residence	8 🗆 Ott	er (Specify)			
ᇤ	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJI (Month, Day, Y		28b. TIN	IE OF	28c. INJ WO	URY AT RK?	28d. DE	SCRIBE HOW	NJURY OCC	URED	
à	2 Accident Investigation	250 BLACE OF IN	HIDV A				ES 2 NO					
윤	3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE OF IN- building, etc.	(Specify)	t nome, farm,	street, fact	lory, office	•	281. LO	CATION (Street or Town, State)	and Number o	or Rural A	loute Number,
3 Suicide 8 Could not be datarmined 29a. PLACE OF INJURY — At home, farm, street, factory, office 29a. CERTIFIER 29a. CERTIFIER Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated.) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICENSE NU	MBER		29d. DATE	SIGNED	(Month, Day, Year)
	Ormy EBR	eine 1	CON				0402	80		► IO	113	195
۵	30. NAME NO AODRESS OF PERSON WI	HO COMPLETED CAUSE O	F DEATH (3	Print)	Sto	370	1 1	Hoen	1110	NA -	21093
	31. OATE (1.50 Arontiny 0.1995	32. MISTERS		SL.	200	216	30	- N	· I NIKY	· · · · · · · · · · · · · · · · · · ·	IACC	1000

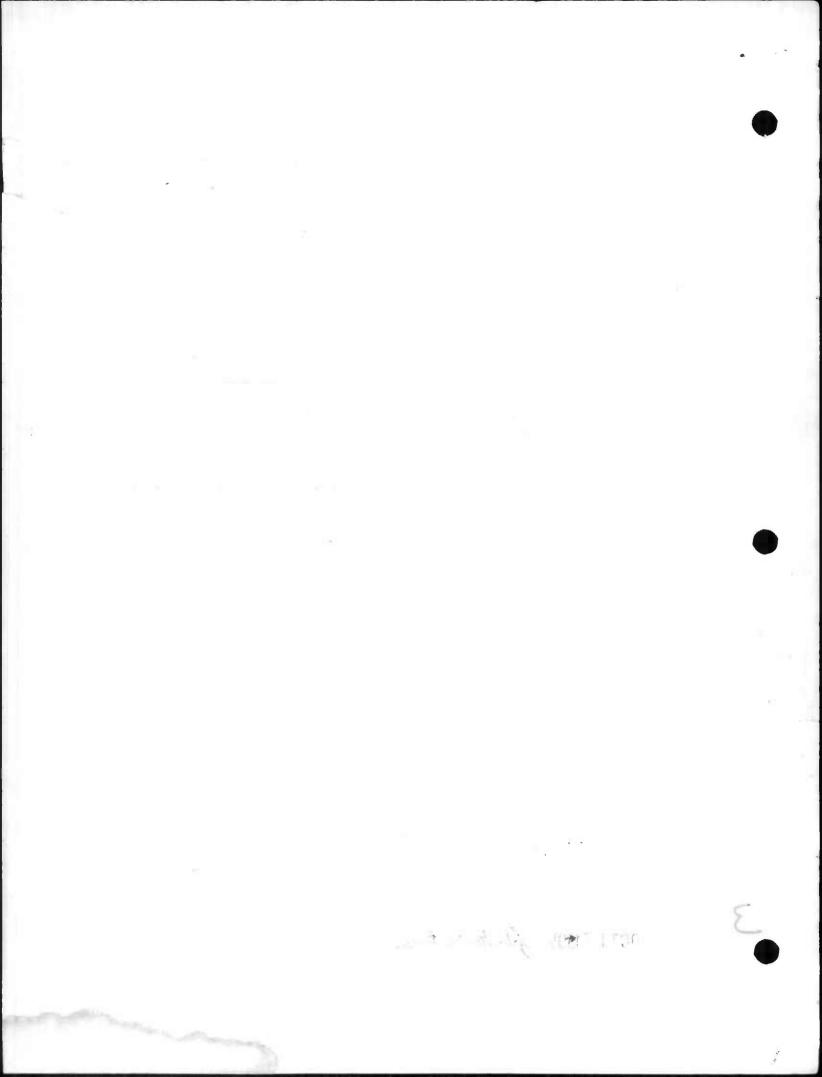


		1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPAR CERTIFI	TMENT OF	HEALTH AND M	ENTAL HYGIE			
		1, DECEDENT'S NAME (First, Middle, Last	L.	Robins GE (in yrs. lasi birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	199	BIRTHPLACE (State or For	
2, 3 should	CTOR	215-78-9690 90. FACILITY NAME (If not institution, give JOSEPH RICHIE		36 YRS.		OR LOCATION OF DEA	Sept. 5		MARYLAND Y OF DEATH	
permit. Pages 1,	Dige	MARYLAND N	тv /А		TOWN DR LOCAL TIMOR	E CITY			10d. INSIDE CITY LIMITS? 1 XXES 2	
. isi	FUNERAL	1359 N. Calhoun			1	21217	U.S.A.			
215-0020 attending physician. se as the burial-transit	Ä	3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YES, GIVE WAR DI	ES 2 X NO	if yes, s	CENDENT OF HISPANIC POOL OF CUIDAN, Mexican, S 2 NO Specify:	DRIGIN? (Specify Y Puerto Rican, etc.)	'es or No 14	Black, White, etc. Specify: BLACK	
2121 al or atte	COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) 11th grade	UCATION de completed) College (1-4 or 5+)	life. Do NOT use	ork done during m	one during most of working				
/LA	10 M		r.			16. MOTHER'S NAM Eva Fra	e (First, Middle, Maide nklin	in Surname)		
be retained be 5 should	F 5			196. MAILING 1359 N	. Calho	end Number or Rural Ro un Street	ute Number, City or To	ore, Ma	ryland 2121	
IMORE Page 6 may to al director, pag	must be	20a. METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Rei 4 Donetion 8 Other (Specify)	moval from State	20b. PLACE AND DATED Cometery, Cremetory or off LOUGON	FDISPOSITION (A	eterv	DATE 20c. L	Baltime	or Town, State	
ALT death.	examiner	21. SIGNATURE OF UNEBAL SERVICE	LOUIN	Lodden	22. NAME A	LIAM C. BI	ROWN COMM			
within 24 hours aft upletely filled in by cremation, or remo		23. PART L Enter the diseases, or ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Rosy	sed the death. Do not neech line. IVA YOUGE S A CONSEDUENCE OF	Faul	ode of dying, auch	as cerdiac or res	piratory arreat	Approximal Interval Bell Onset and	
P.O. BOX 6871 th certificate be executed ending physician and com	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	· Endoc	S A CONSEQUENCE OF S S A CONSEQUENCE OF S CA LIMM		DeXicano	y Dis	easp	198	
RECORDS, Prequires that the death been signed by the attent of Health and Mental H	3 .	PART II. Other significant condition	ons contributing to death			4	art I. 24a. WAS A	IN AUTOPSY DRMEO?	24b. WERE AUTOPSY FIN MAILABLE PRIOR T COMPLETION OF CA OF DEATH?	
law law	23 shov		TRIBUTE TO CAUSE				0		1 🗆 YES 2 🕞 🕏	
PHYSICIAN: The this certificate ha	E 0	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence 8	-Other (Specify)	Hosba	e,	
G PHYSIC er this ce	E .	M 1 → Netural 5 Pending	28a. DATE DF INJUF (Month, Day, Yea		RY W	JURY AT CORK? YES 2 ND	8d. DESCRIBE HOW	INJURY OCCUR	ED	
OR ATTENDING DIRECTOR: After Dours after death	28 is TED	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE DF INJU building, etc. (S	JRY — At home, farm, st pecify)	reet, factory, offi	ce 2	181. LOCATION (Street City or Town, Stett	t end Number or I e)	Rural Route Number,	
S S S	AP L		BICIAN: To the best of my kn							
TO THE HOSPITAL TO THE FUNERAL De filed within 72	BE	296. ORGANISHE AND TYTLE OF CENTIFIE		D		29c. LICENSE NUMB		29d. DATE SI	IGNED (Month, Day, Year)	
>	₹ 2	TO THE AND ADDITEDS OF TEMPOR W	HO COMPLETED CAUSE OF		J8 N.	Gulars	X. Bala	6.14	121201	

		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND DEATH	MENTAL HYGI				
		1. DECEDENT'S NAME (First, Middle, Last)	shine J	TR			2. DATE OF DEATH	DAY	YEAR	TIME OF DEATH	
pp		217-46-3155	5. SEX 8. AGE (In yrs. lest birthday) F UNDER 1 YEV 50 YRS. MONTHS DAY			IF UNDER 24 HRS. HOURS MIN.	1945	. BIRTHPLACE (State or Foreign Country) Maryland			
. 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give stree Howard County Gen RESIDENCE OF DECEDENT		tal		or Location of Di	EATH		ry of DEATH		
physician. burial-transit permit. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY	l County				INSIDE CITY LIMITS? YES 2 K NO				
n. ansit perm	FUNERAL	10e. STREET AND NUMBER 12885 Old Frederi	ck Road		10	1. ZIP CODE 21.784		U.S	EN OF WHAT		
	COMPLETED BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2/L NO	If yes, sp	CENDENT OF HISPAI lecify Cuben, Mexica 3 2 X NO Specifi	NIC ORIGIN? (Specify in, Puerto Ricen, etc.) y:	Yes or No-	Black, Whi	mericen Indian, Ite, etc.	
or aftend			TION mpleted) College (1-4 or 5+)	(Give kind of life. Do NOT u		ost of working		BUSINESS/INDU	ISTRY	MILLEC	
by the hospital be detached it at once.		12 17. FATHER'S NAME (First, Middle, Last)	2	Dair	y Farmer	18. MOTHER'S NA	ME (First, Middle, Mei	ricultu den Surname)	re		
retained 5 should notified	TO BE	John L. Rhine, S 190. INFORMANT'S NAME (Type/Print) Mrs. Susan L. Rhin		19b. MAILING 128	ADDRESS (Street of 85 01d F	and Number or Rural I	t Pope Route Number, City or Road Syl	Town, State, Zip C	e, MD	21784	
age 6 may be director, page er must be		20a. METHOD OF DISPOSITION 1 th Burlat 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	of from State	p. PLACE AND DATE			1	LOCATION — CI			
death. P e funeral il.		21. SIGNATURE OF PUNERAL SERVICE LICEN	Hais	4	HAIG		AL HOME MD 21784				
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		23. PART I. Enter the diseases, or conshock, or heart fellura. Lis IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	Septic	ach line.	not enter the mo	de of dying, suci	h aa cerdiac or re	epiratory arre	st,	Approximate interval Between Driset end Deeth 24 hars	
th certificate be execuending physician and I Hyglene prior to bur or other traumatte	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
that the ded by the hand Men	CAL	PART ii. Other algnificant conditions of	contributing to deeth b	ut not resulting	in the underlying	g ceuse given in	PERI	AN AUTOPSY FORMED?	AMAIL	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE	
v requires been sign t, of Healt shows	N: MEDIC	DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	F DEATH YE	s 🏿 NO 🗆] UNCERTAIN		2 (JNO	OF D	YES 2 NO	
	PHYSICIAN:		OSPITAL: XInpetient 2 - ER/Outp		OTHER:	e 5 🗆 Residence	6 Other (Specify)				
PHY this with	D BY PH	1 S Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28e. DATE OF INJURY (Month, Day, Year)	- At home, ferm, a	M 1 1	RK? /ES 2 NO	28d. DESCRIBE HO			Number,	
DIR DIR	COMPLETE	4 Homicide determined 29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIA	building, etc. (Spec	<i>(17)</i>			City or Town, St	ete)			
TO THE HOSPITAL TO THE FUNERAL De filed within 72			On the basis of examination				time, date end place,	end due to the			
TO THE DE filed IMPOR	TO BE	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	D46121	0	Pa	t 10	1995	
6		J1. DATE FILED (MORD. DOY, YOU) 1995	22 RECIETE PER CION	ATURE .	Rd, Su,	te 200 E	c, colum	bia, M	0 21	044	
		-0,2,1000	Inti- Develop	rhadall						DHMH-18 Rev 1/8	



		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTMENT CERTIFICAT	IT OF HEALTH AN	ID MENTAL	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) - Ronnie Saunde	DONNIE	VINCENT SA	IINDEDC	2. DATE OF	DAY	3. TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER			ER 1 YEAR IF UNDER 24 H	Octo		.995 1647 p		
무		215-60-3692	1 XM 2 □ F 40 →	11 YRS. MONTH	DAYS HOURE M	Month, 5/6/-	54 55	BALTIMORE, MD		
2, 3 should	TOR	9a. FACILITY NAME (If not institution, give st	Wolfe St.		ry, town on Location of			n/a		
permit. Pages 1.	DIRECTOR	10a. STATE 10b. COUNTY	/a	10c. CITY, TOWN	OR LOCATION			10d. INSIDE CITY Y LIMITS? YES 2 NO		
		10e. STREET AND NUMBER		- Dr	101. ZIP CODE	1005		ZEN OF WHAT COUNTRY?		
020 physician. burial-transit	FUNERAL	1830 ASHLAND A	VENUE		. WAS DECENDENT OF H	L205		TED STates 14. RACE — American Indian,		
O B a	BY FL	1) Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuban, M 1 YES 2 NO S	axican, Puerto Ric		Black, Write, etc. Specify: BLACK		
or attending or attending or use as the	TED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	6a. DECEDENT'S USUAL (Give kind of work dor life, Do NOT use retired	e during most of working	16b. K	IND OF BUSINESS/IND	USTRY		
ND 2- hospital o lached for	COMPLET	Elementery/Secondary (0-12) 12 th	College (1-4 or 5+)		CHANIC/JANI	TOR V	arious p	laces		
YLA by the be de	E CON	17. FATHER'S NAME (First, Middle, Last) JAMES SAUND	ERS		18. MOTHER	SHAME CEC	GOL DMÁN			
	TO B	190. INFORMANT'S NAME (Type/Print) CECELIA SAU	INDERS	19b. MAILING ADDRE	ss (Street and Number or F ASHLAND A	VENUE,	el Route Number, City or Town, Stele, Zip Code) ENUE, BALTIMORE, MD 21205			
ALTIMORE, death. Page 6 may be funeral director, page		20a. METHOD OF DISPOSITION X M Burlel 2 Cremation 3 Remo	wal trom State 20b.Pi	LACE AND DATE OF DISP	OSITION (Name of	10-19	20c. LOCATION —	City or Town, State ORE C, MD		
ALTIMOR death. Page 6 ma e funeral director, p. I. examiner must		21. SIGNATURE OF FUNERAL SERVICE LICE			. NAME AND AGORESS O		DACTIN	7KE C, 110		
0 - 0		Simet	te L. Su	nes				NORTH AVENUE		
urs in t			omplications that caused the list only one cause on each	he deeth. Do not ent h line.	er the mode of dying,	such as cerdia	c or reapiratory arr	Interval Between		
d with ho ompletely filled I, cremation, o		IMMEDIATE CAUSE (Final disease or condition reaulting in death)	Crypto	c. Meneno	itis			2 Weeks		
8 5 . 6	z	Samuel Hart and Hart	AIDS	ONSECUENCE OF).				months		
be be	ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	E-AIN A						
certificat oding phy Hygiene p	RTIFICATION	CAUSE (Disease or Injury that Initiated evente reaulting in death) LAST C. HIV Infection OUE TO (OR AS A CONSEQUENCE OF):								
S, deat deat Aemtal	AL CE	PART II. Other algnificent conditions	contributing to deeth but	not regulting in the	underlying ceuse give	n in Part I. 2	Ia. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
that the and any I	DICA						PERFORMED? ☐ YES 2 ☑ NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
requi	MEDIC						7	1 YES 2 NO		
I law has b Dept	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH	1 (Check only one)				
VITAN: The CIAN: The State or Item	YSIC	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 [XER/Outpatie	ent 3 DOA 4 N	ER: ursing Home S□ Reside	nca 6 🗆 Other (S	Specify)			
NO PHYSICIAN: The this certifical auth with the St marked, or It		27. MANNER OF DEATH 1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?		IBE HOW INJURY OCC	CURED		
After death	ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, atreat, to		261, LOCAT	ON (Street and Number Town, State)	or Rural Route Number,		
	PLET	290. CERTIFIER 1 X CERTIFYING PHYSIC	DIAN: To the best of my knowled	ge, death occurred at the	time, data and place, and	I due to the cause	(e) and manner se state	-4		
보 나 아 두	COMPL							e cause(s) and menner ee stated.		
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE C	296. SIGNATURE AND TITLE OF CERTIFIER	100		29c. LICENSE	NUMBER	29d. DATE	E SIGNEO (Month, Day, Year)		
2 2 3 W	0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	A STEM 27) /Sons Count	D4631	12	1	0/16/95		
3		Vincent Okeke			tion Ctr	401 I	Facer	C+ 21202		
			Jalin d'awaleon	DE CEI	OTOH COL	- 1 01 1	. Lauer	26. 21202		
	1 1	OCT1 71995	your authoris	nardall						



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PHYSICIAN: MEDICAL CERTIFICATION

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equires	an sign	of Heal	HOWS
law r	as be	Dept.	23 s
The	cate h	State C	item
ICIAN	certifi	the	0
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed will 24 hours after death. Page 6 may be retained by the hospital or attending phy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the b	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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95 31186 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Wanda Mary Shafferman October 14,1995 2:15 A. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 220-26-9368 1 - M 2 X F 68 Aug. 27,1927 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 7244 River Drive Road Edgemere Baltimore 10b. COUNTY 10a. STATE 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Edgemere 1 - YES 2 X NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7244 River Drive Road 21219 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 X Married 1 TYES 2 NO Specify Specify 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify or Elementary/Secondary (0-12) College (1-4 or 5+) G.E.D. Clerk Typist Federal Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Google Lillian Miller Issac Glaze 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. Shafferman 7244 River Drive Road Edgemere. Maryland 20s. METHOD OF DISPOSITION

UC Burlai 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Ather (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata Rocky Gap V.A. Cemetery 10/17/95 Flinstone, MD 21. SMINATURE OF TWEERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. MD 23. PART I. Enter the Glacus Enter the Ulassass, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory streat, shock or heart moure. List only one cause on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition Cara 10 month resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST

PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO 🗹 UNCERTAIN 26. PLACE OF DEATH (Check only orle. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL . 1 YES 2 NO

Inpetient 2 ER/Outpatient 3 DOA 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF

4 ☐ Nursing Home 5 | Residence 8 ☐ Other (Specify) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

26250

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated.

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

natilda (nu) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

> 1447 York Road, Lutherville, Maryland Matilda So, M.D.

31. DATE FILED (Month, Day, Year) OCT 1 7 1995

27. MANNER OF DEATH

5 Pending Investigation

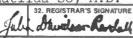
8 Could not be

1 Natural

2 Accident

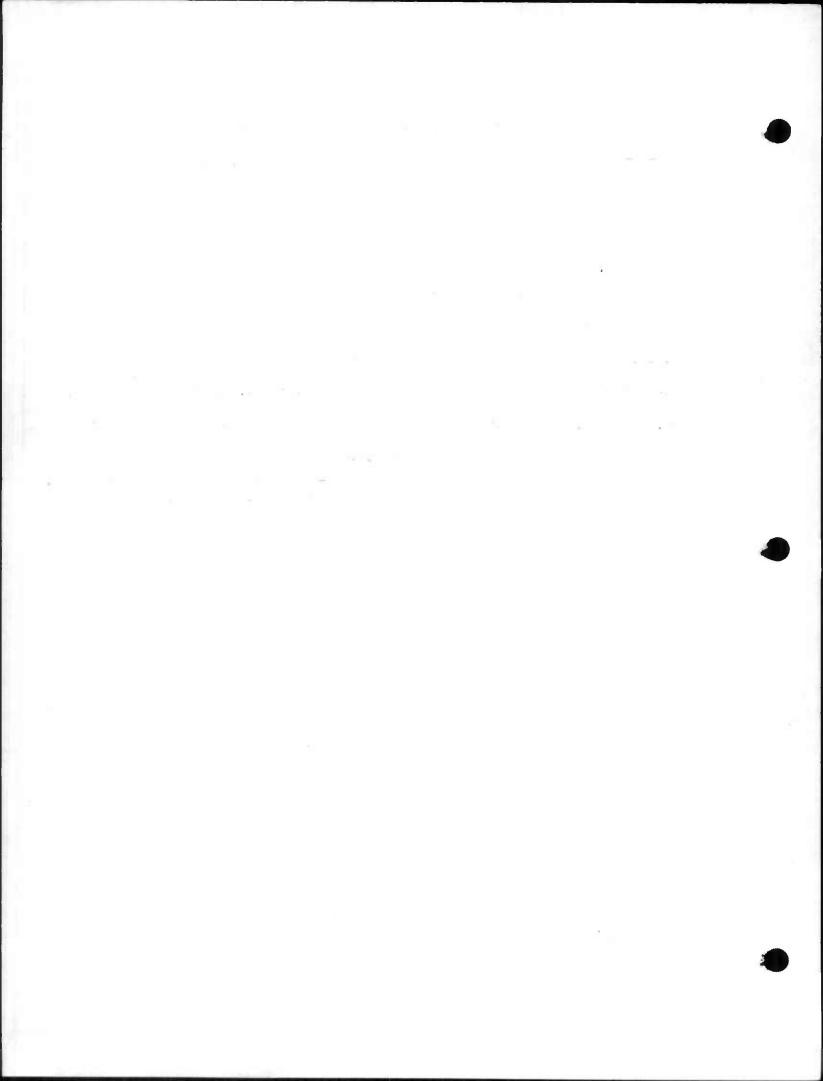
3 Sulcide

4 Homicide



H. 50

10/16/95



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

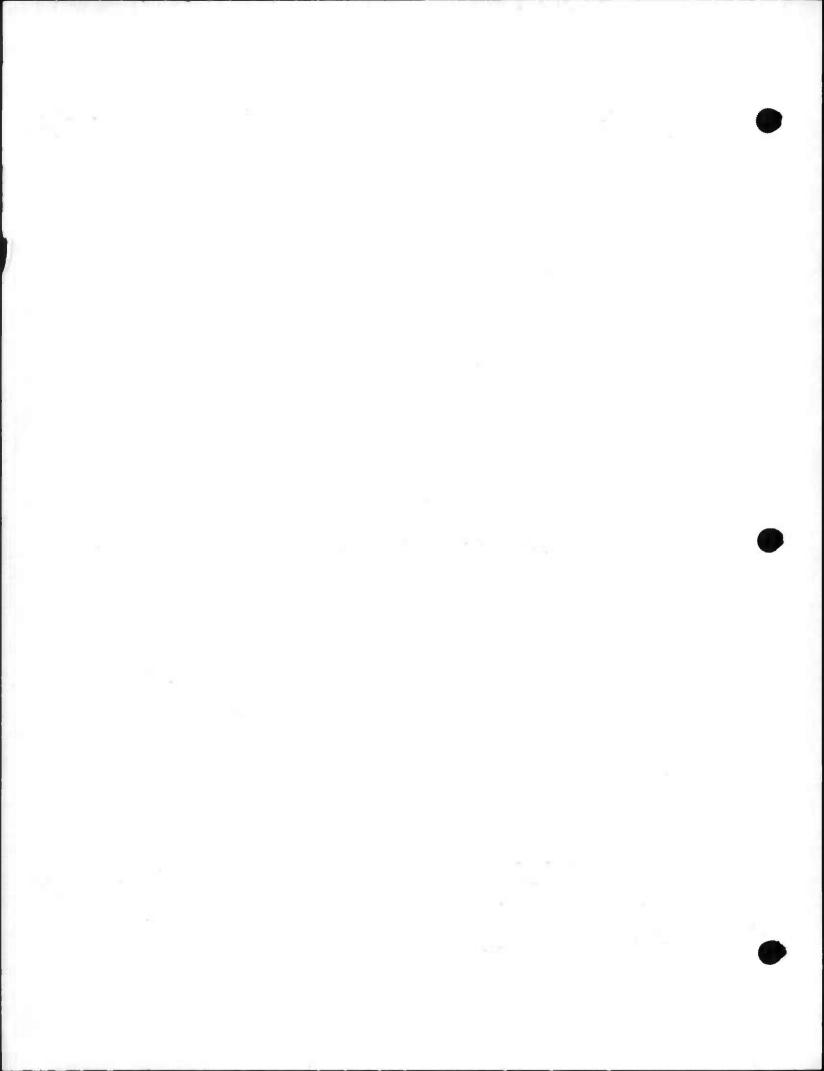
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

_	FOR STATE REGISTRAR		STATE OF M	ARYLAN		TMENT OF I		MENTAL HYGIE		
:	t. DECEDENT'S NAME (First,	eth	Compr 5. SEX		Spu s, lest birthday)	F ONDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEATH	DAY 15, 19	3. TIME OF OEATH VEAR 1 0 0 N 8. BIRTHPLACE (State or Foreign
	112-16-7797 9e. FACILITY NAME (If not in	stitution, give st	1 M 2 F	79	YRS.	9b. CITY, TOWN	HOURS MIN.	Jan. 13,	1916	New York TY OF DEATH
	Carroll Co			Westminister					Car	roll
L DINECTOR	Maryland 100. STREET AND NUMBER	Carro				estminis			100 CIT12	10d, INSIDE CITY LIMITS? 1 YES 2 NO EN OF WHAT COUNTRY?
DI FUNERAL	11. MARITAL STATUS t Never Married 2	201 St. Marks Way Apt. 10 11. MARITAL STATUS 12. WAS OCCEDENT EVER IN I FORCES? 1 YES 3. Wildowed 4 Divorced 12. WAS OCCEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT					21158 CENDENT OF HISPA	NIC ORIGIN? (Specify ten, Puerto Ricen, etc.)	S.A. 14. RACE — American Indian, Black, White, atc. Specify:	
ILLEIEU								OWD HO		ISTRY
COMPL	17. FATHER'S NAME (First, M.		y y s			Joket	16. MOTHER'S NA	AME (First, Middle, Meid		
10 00	John B. 190. INFORMANT'S NAME (7)	Cumm'	ings		100			Route Number, City or T		1
-	Tane Shiples 20a, METHOD OF DISPOSITI t Surlel 2 Cremetto 4 Donetton 5 Other	ION en 3 □ Remo (Specify)	1		CE AND DATE	Sunset OF DISPOSITION (N ther piece) rk Cemet	ame of	1.	LOCATION — C	and 21048 By or Town, State ore, Maryland
	21. SIGNATURE OF INTREST	0	1. /á	S)	1	Ruck		Tuneral Ho		1050 York Rd c.Towson,Md.
	23. PART I. Enter the di ehock, pr hi IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to imme-	eart failure. I	DUE TO	OR AS A CO	e deeth, Do i line.	Ten D	tion	th sa cardlec or rea	piratory arre	Approximate interval Batweer Onset and Death First Minn &
	cause, Enter UNDERLYI CAUSE (Disease or Inju that initiated eventa resulting in death) LAS	ing {	OUE TO	OR AS A CO	NSEQUENCE O	cular Fi:	Accide	nt		Two Day
MEDICAL	PART JI. Other significa Change R Change Cha Change Change Cha Change Cha Cha Cha Cha Cha Cha Cha Cha Cha Cha	Obstan	Failurd Po	ma	n Dis	last		PERF 1 TYES	AN AUTOPSY ORMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIOIN	25. WAS CASE REFERRED TO					TH (Check only one,		NEI		
5	EXAMINER?		HOSPITAL:	ER/Outpatie	nt 3 🗆 DOA	OTHER: 4 - Nursing Hor	ne 5 🗆 Residence	8 Other (Specify)		
		Pending Investigation	28e. DATE OF (Month, De	ly, Year)		M 1	JURY AT DRK? YES 2 NO	26d. DESCRIBE HOV	Y INJURY OCCI	URED
3		Could not be determined	28e. PLACE Of building,	Hc. (Specify)	At home, ferm,	street, fectory, offic	ie .	28f. LOCATION (Street City or Town, Ste	et and Number o	or Bural Route Number,
COMPLE	2							e to the cause(s) end no time, date end place,		d.
0 00 01	29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	1 n	Or	F OF DEATH	(ITEM 27) (Type	Print) i	29c, LICENSE NU	WBER C	29d, DATE	SIGNED (Month, Day, Year)
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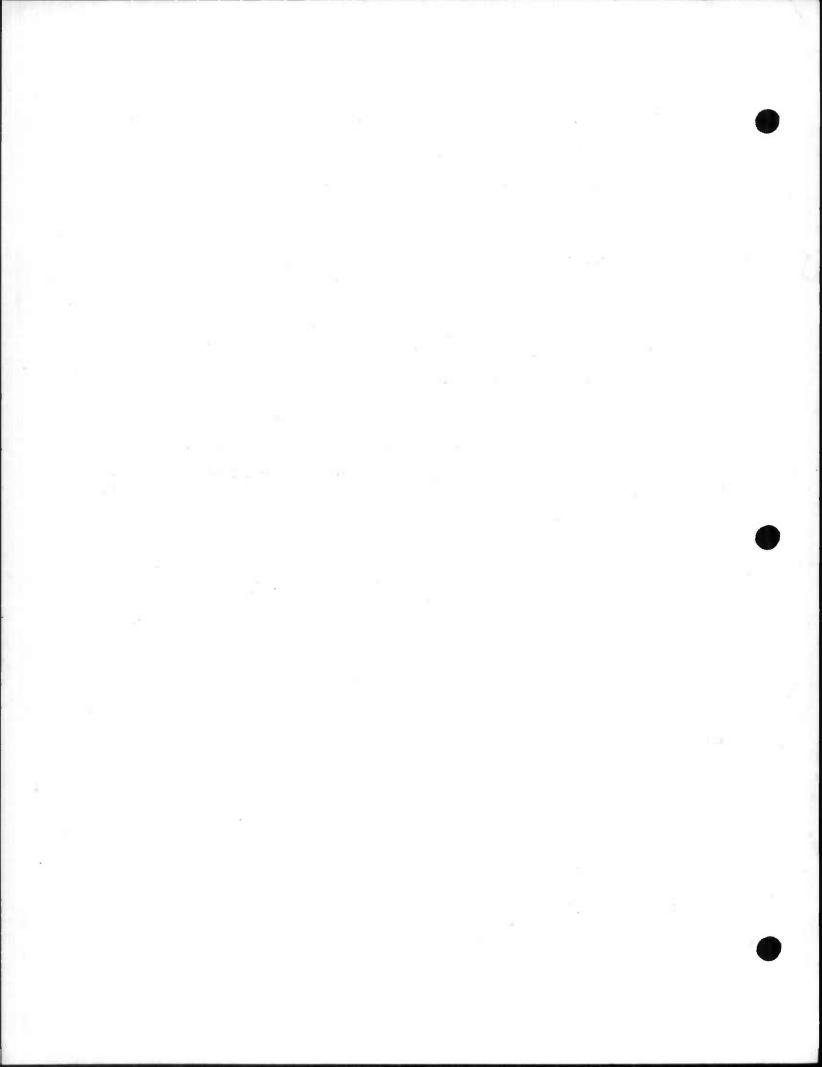
		1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPAI	RTMENT OF	HEALTH AND	MENTAL HYG			
		1. OECEDENT'S NAME (First, Middle, Last)	L. Se	along			DATE OF OBAT	17/2,19	YEAR S. TIME OF DEATH,	
Pin		4. SOCIAL SECURITY NUMBER 215-14-7240	1 XM 2 DF 73	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan. 7	"1922	BIRTNPLACE (State or Foreign Country) Maryland	
1, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give states of the state of the states of the s			Belts	ville	DEATN		ry of OEATH ICE George	
Pages	DIRECTOR	Maryland Prin	ce George	e George Beltsville					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
an. ransit permit.	FUNERAL	6301 Muirkirk Roa		101. ZIP CODE 20705					EN OF WHAT COUNTRY?	
-0020 fing physician, the burlat-transit	B₹	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, s	CENDENT OF HISPA pecify Cuban, Mexic S 2 X NO Spec	ANIC ORIGIN? (Special Control of	ly Yes or No	4. RACE — American Indian, Black, White, etc. Specify: White	
21215-0020 ital or attending physic d for use as the burial	TO BE COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	6a. DECEDENT'S (Give kind of life. Do NOT to		ION ost of working		F BUSINESS/INDU	on Industry	
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.		Grade 6 17. FATHER'S NAME (First, Middle, Last) Howard L. Sealing		CONTLE	actor		AME (First, Middle, Mi	alden Surname)	MI INCOSCLY	
		19a. INFORMANT'S NAME (Type/Print) Elmer Frederick S			and Number or Rural ord Driv	Route Number, City of	on, Mary			
OR ector, p		29a. METHOD OF DISPOSITION 1 N Burlel 2 Cremation 3 Remark 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	oval from State Carago		of disposition (A	tery	10/16	e. Location — co Brentwoo	od, Maryland	
0 - 0		· Greye S	Ky		Dona 313	Talbott	neral Ho	Laurel,	Maryland 20707	
760 ed within 24 hou completely filled is al, cremation, or event, the me	7	23. PART I. Enter the diseases, or cahock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only Die cause Dn eacl	h line.			2. Allra		Interval Between	
P.O. BOX the certificate be exempled by the prior to or other traum	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated aventa reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
that the ed by the th and M	MEDICAL C	PART II. Other aignificant condition	e contributing to death but	not resulting	in the underlyin	g ceuse given in	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH?	
law requas been Dept. of 23 sho		DID TOBACCO USE CONTR			ES NO C		N 🗗		1 TES 2 NO	
- F 2 2 5	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpatie		OTHER:		6 Other (Specify,)		
ON OF VI DING PHYSICIAN: After this certifica death with the St marked, or It	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		JURY W	JURY AT DRK? YES 2 NO	28d. OE\$CRIBE N			
DIVISION OR ATTENDING DIRECTOR: After hours after death item 26 is ma	ETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)				City or Town, S	State)	Rural Route Number,	
로 가는 등	COMPL	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowled R: On the besis of examination si							
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	201. SHOWATHRE AND TITLE OF CERTIFIER	Delugue V	WS		29c. LICENSE NU D2123		Octo,	SIGNED (Month, Day, Year)	
11/5		Augusto P. Rod 31. DATE FILED (Month, Day, Year)	riguez M.D.	5009		n Ct.,	Camp S	orings	MD 20748	
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FOR STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH DCTOB BR 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 86 DAYS 215 03 6853 1 M 2 X F Feb. 24, Maryland the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Harbor Hospital Center Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Baltimore 1 YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 101 7IP CODE 10g. CITIZEN OF WHAT COUNTRY? 5611 Patrick Henry Drive 21225 U.S.A. retained by the hospital or attending physician, 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE --- American Indian, Black, White, etc. 1 Never Merried 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 7 NO Specify: BY Specify: 3 Widowed 4 Divorced White use as COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ğ Elementary/Secondary (0-12) College (1-4 or 5+) 9th Home Maker detached Own Home 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William Creighton should be notified at Grace Elizabeth Darrell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 page 5 s Joann Dolle 5611 Patrick Henry Drive Baltimore, Maryland 21225 hours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 M Burial 2 ☐ Cremation 3 ☐ Ramoval from State funeral director, Cedar Hill Cemetery 4 Donation 5 Other (Specify) 10/14 Baltimore, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 and completely filled in by the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23. PART i. Entar tha diseases, of shock, or heart failure. List only one cause on each line. interval Between 6 IMMEDIATE CAUSE (Finsi Onset and Dasth UROSEPSIS cremation, the disesse or condition event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed Hygiene prior to burial, DEHY DRA710N traumatic CERTIFICATION Sequentisity list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate HEART FAILURG FUNERAL DIRECTOR: After this certificate has been signed by the attending physician within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to the death certificate be CONGESTIVE cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY any 1 WES 2 NO OF DEATH? requires Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO M UNCERTAIN AM. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item **EXAMINER?** OTHER: 1 YES 2 70 1 mpetient 2 ER/Outpetient 3 DOA ng Home 5 - Residence 6 - Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked. Natural 1 YES 2 NO BY investigation DR ATTENDING 2 Accident 28a. PLACE OF INJURY — At home, farm, strast, factory, office building, etc. (Specify) Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) end manner as stated. TO THE HOSPITAL TO THE FUNERAL C DE FILED WITHIN 72 h HOSPITAL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER AS 244/6 BE 29d. DATE SIGNED (Month, Day, Year) 244/6/4 DC70BER 10, 1995 2 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 SHANOVER ST, BALTIMOR HARBOR HOSPITAL 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

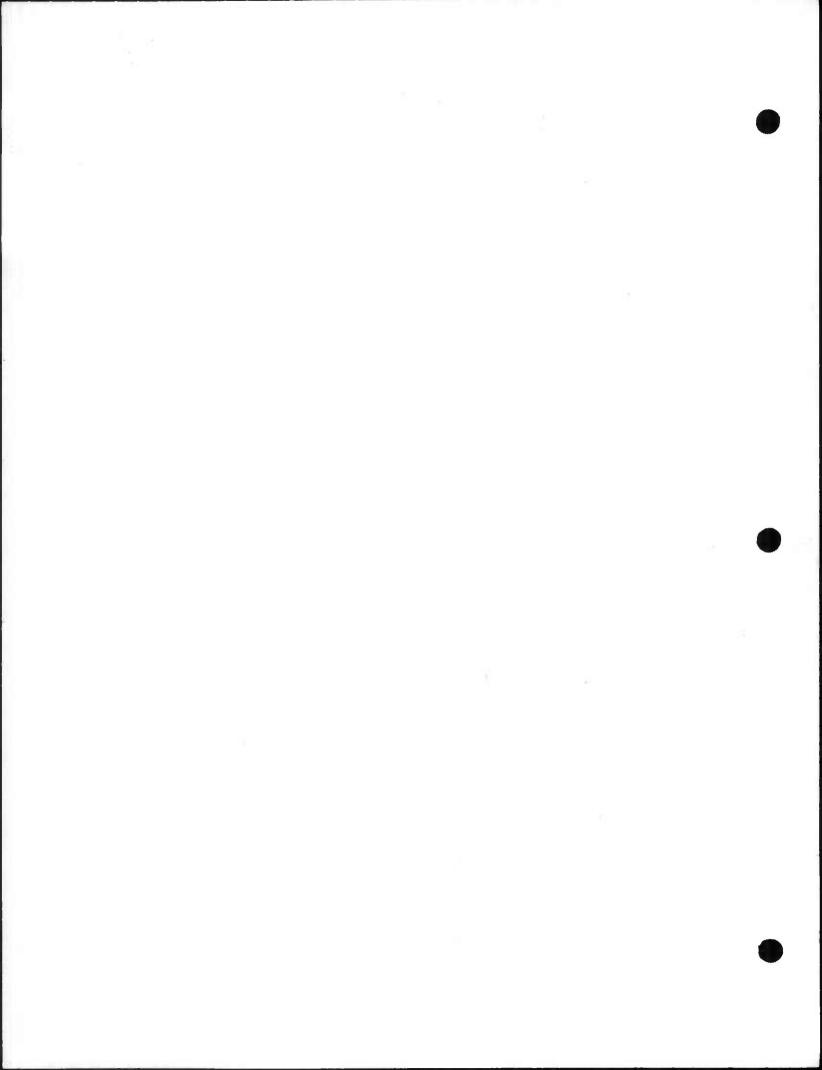


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RECORDS, 1
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Midele, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1:30 P nennin 10 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 4-12-16 213-07-4906 DAYS HOURS MIN. 1X M 2 | F 79 MARYLAND YRS Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOPKINS - BAY VIEW BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 106 COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYT AND N/A BALTIMORE X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1600 S. KANE STREET 21224 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. Never Married 2 Married BY 3X Widowed 4 Divorced WHITE. COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 pr 5 +) 12 YEARS WIRE MILL BETH. STEEL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 THEODORE SCHENNING BE KRANTZ. notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 MR. THEODORE SCHENNING 6414 HARTWAIT STREET BALTO. MD. 21224 Page 6 may be 9 20a. METHOD OF DISPOSITION

1X Burisi 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must SACRED HEART OF MARY CEM. 10-11 4 ☐ Donation 8 ☐ Other (Specify) _ BALTO. CO. MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME death. 1201 DUNDALK AVENUE BALTO, MD, 21222 and completely filled in by the purial, cremation, or removal. hours after medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart fallura. List only one cause on each line. interval Batwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition within 24 adenocarcinoma event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to 1 if any, leading to immediate cause. Enter UNDERLYING been signed by the attending physician it, of Health and Mental Hygiene prior to certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a, WAS AN AUTOPSY Loen venous amy thrombosis 1 - YES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🔀 PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The certificate I HOSPITAL: OTHER: 1 - YES 2 NO Inpatient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 all a 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED DIRECTOR: After this c marked. 1 Netural
2 Accident
3 Suicide 5 Pending M 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 8 Could not be 4 Homicide 28 determined tem 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) FUNERAL within 72 t = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 10/8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) HODKING Ba /32. REGISTRAR'S



1 - FOR STATE REGISTRAR

REG. NO.

be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained in	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified
	2	2 8	M

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH SAMPLE REGINALD 1995 11:55 PM OCTOBER 10 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Mar. 31 1966 1 XM 2 - F 29 MARYLAND 214-78-6367 9e. FACILITY HAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A SHOCK TRAUMA OF BALTIMORE BALTIMORE 10a. STATE 18b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE CITY 1 X XYES 2 \ NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEH OF WHAT COUHTRY? 2836 CARVER ROAD 21225 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Ho-14. RACE — American Indian, Black, White, stc. 1 Never Married 2XX Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 X HO Specify: BY 3 Widowed 4 Divorced **BLACK** COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIHD OF BUSINESS/INDUSTRY (Spe Elementary/Secondery (0-12) College (1-4 or 5+) 12th grade Warehouse Worker Woodward & Lothrop 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surneme) Thomas R. Baker Mable Sample 19a. INFORMANT'S NAME (Type/Print) 2 <u>Mable Sample</u> 2836 Carver Road, Baltimore, Maryland 21225 20e, METHOD OF DISPOSITION
11 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Zion Cemetery 10/13 Baltimore, Maryland 21. BIGNATURE OF FUNERAL SERVICE LICENSE WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata intervai Batween ahock, or heart fellure. List only one cause on each line. Onset and Death IMMEDIATE CAUSE (Final 0 disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significent conditions contributing to death but not requiting in the underlying cause given in Part i. 24s. WAS AN AUTOPS 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? YES 2 NO 10 YES 2 1 NO YES | NO X DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only) **EXAMINER?** OTHER: 1 YES 2 NO
27. MAHHER OF DEATH □ Inpatient ★ ER/Outpatient 3 □ DOA 4 Hursing Home 5 8 Other (Specify 28e. DATE OF IHJURY (Month, Day, Pear) 28b. TIME OF 28c. IHJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 95 М 1 YES BY 10/ 2 Accident PLACE OF IHJURY — building, etc. (Specify) 3 Suicide 6 Could not be COMPLETED Loved 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) and (Check only XX MEDICAL EXAMINER: On beele of examination end/or investigation, in my opinion, death occured at the time, date end place end due to the ceuse(s) end menner se stated. TURE AND TITLE OF CERTIFIER 29c. LICEHSE HUMBER 29d. DATE SIGHED (Month, Day, Year) BE OCTOBER 11,1995 O.C.M.E. 2 Penn Street, Baltimore, Maryland 21201

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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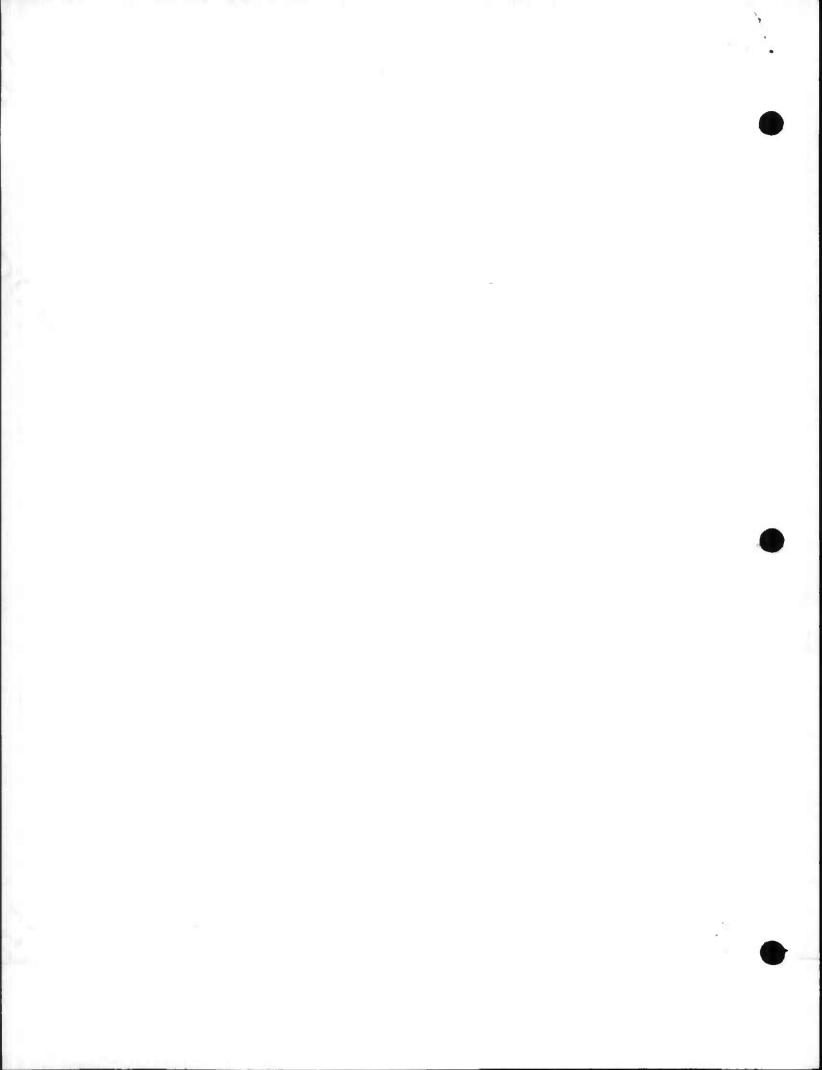
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH 3. TIME OF DEATH DOROTHY SPARROW HTHO 12:52 M 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 214-14-5236 1 M 2 FF 3 10 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BONSELOURS DIRECTOR MORKE N/A RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO within 24 nours after death. Page 6 may be retained by the hospital or attending physician. spetcy filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1262 Glyndon Avenue 21223 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ves or No 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto 1 YES 25 NO Specify: 1 Never Married 2 Married BY 3X Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Given kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done during mille, Do NOT use retired.) dery (0-12) College (1-4 or 5+) 9 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) 76 William A. Grienus Caroline Wehenburg BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Robert G. Sparrow Jr. (Son) 1137 Mount Drive Pasadena, Maryland 21122 9 20a. METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametary, crematory or other place) OCT. 19, 1995 20c. LOCATION -- City or Town, State must cometery, cremetery or other place) UCT. Cedar Hill Cemetery Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF EMPERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes filled in by the fillion, or removal. 1630 Edmondson Avenue Catonsville, Maryland medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death completely filled inial, cremation, (the disease or condition_ resulting in death) traumatic event, DUE TO (OR/AS A CONSEQUENCE OF executed prior to burial, CERTIFICATION and Sequentially list conditions, if any, leading to immediate attending physician cause. Enter UNDERLYING CAUSE (Disease or injury certificate be luma other that initiated events resulting in death) LAST 6 has been signed by the atter Dept. of Health and Mental injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY that shows any 1 TES 2 THO laidio vos en 1 YES 2 NO PHYSICIAN: SW. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) H Hem State After this certificate HOSBITAL:
1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 6 the 27, MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 Natural 5 Pending Investigation 1 YES 2 NO death BY 2 Accident TO THE HOSPITAL OR ATTENDIN TO THE FUNERAL DIRECTOR: Aft be filed within 72 hours after der IMPORTANT: If Item 28 is r 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of sxamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as state 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Cru Z TUR 10 25 15 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CRUZ BON SECOURS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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After death

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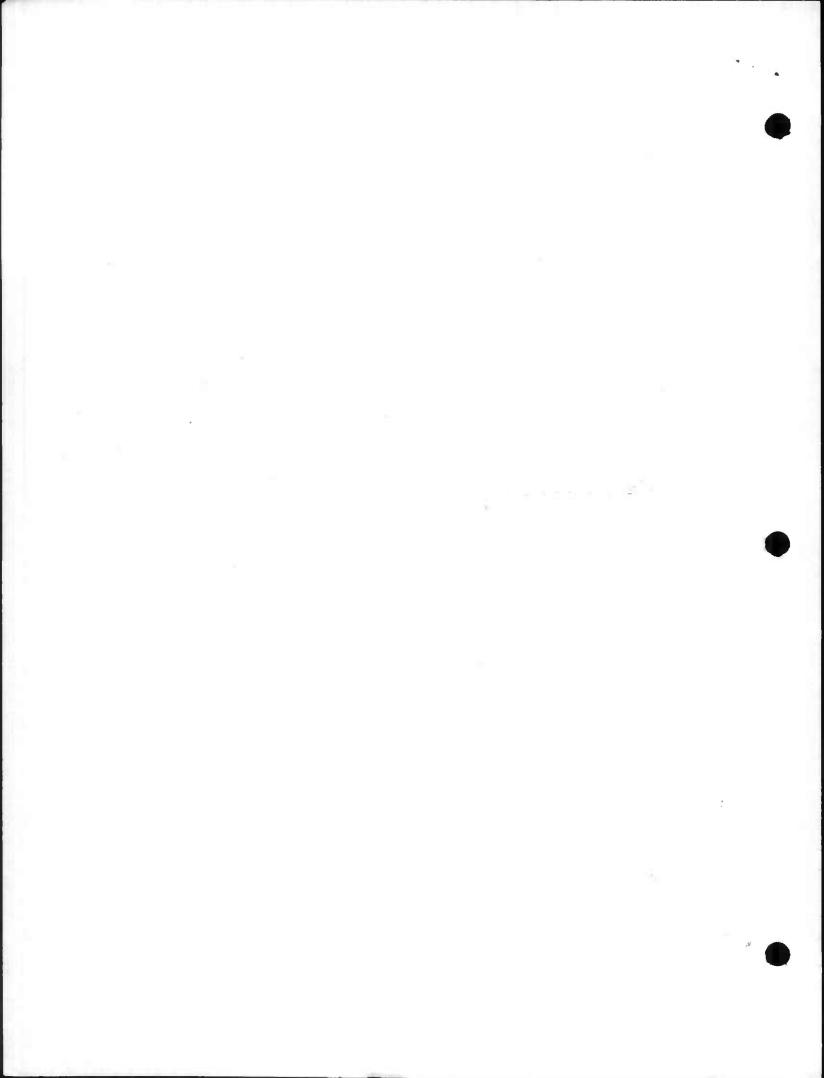
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ATTENDING
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Shirley Jean Spaide Oct. 1995 11:15 P. M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH B. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 1 M 2 KF 201-24-6090 Aug. 14,1930 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number 95 CITY TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 6012 Chesworth Road Catonsville Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Catonsville Maryland 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6012 Chesworth 21228 Road U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Administration Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Disability Examiner Social Security 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) notified at John Duffy Lucas Thesia Jane Payne 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Roland N. Spaide (Spouse) 6012 Chesworth Road Catonsville, Maryland 21228 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Metro Crematory Oct. 16, 1995 Catonsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes issellan 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between ahock, or heart failure. List only one cause on each line Onset and Death IMMEDIATE CAUSE (Final diseese or condition Carcinoma resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 TES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) TO 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 28 29e. CERTIFIER 1 (Chank nature) 1 (CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated FUNERAL I within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as steted. 296. SIGNATURE AND TITLE-OF CERTIFIER 29c LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE DO4652 0116195 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MECH mD 3449 WILKENS 32. PEGISTRAR'S SIGNATURE 7 1995 Davelson Rodald



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

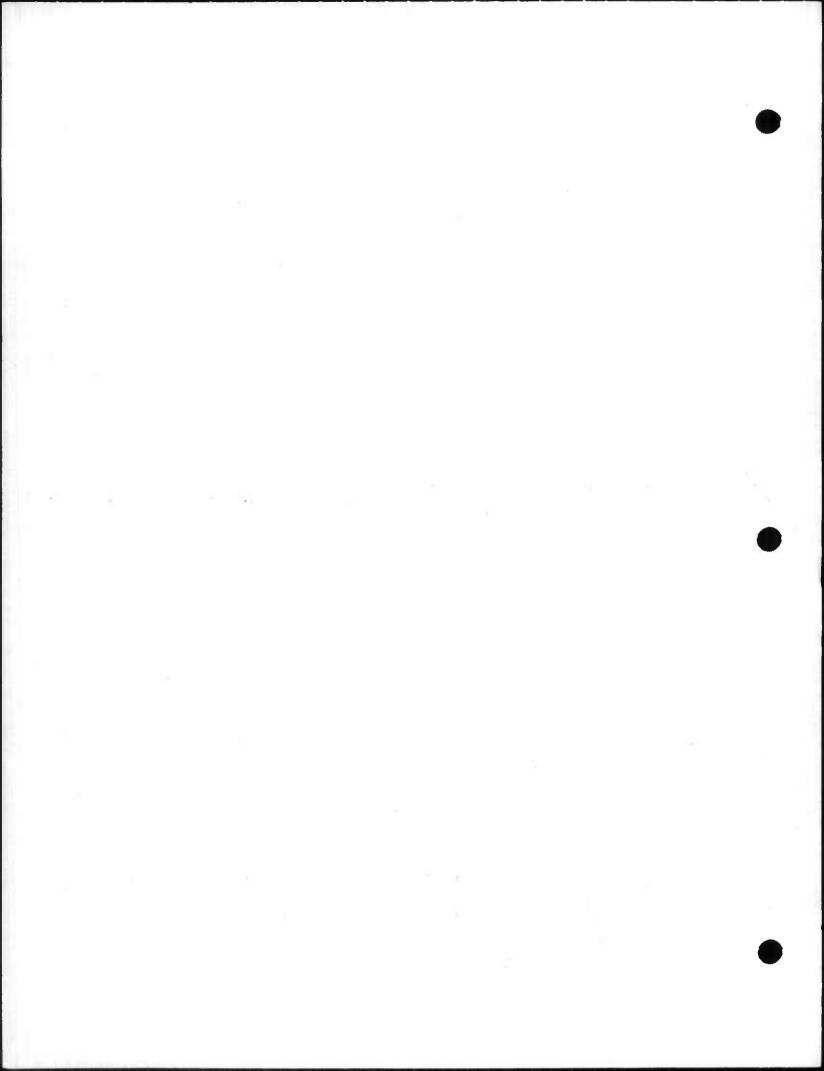
TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M	ENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTA	AL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)	iteinberg		<u> </u>	DEATH	MON	E OF DEATH		EAR	IME OF DEA		
	Hyman 3		h yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	_	FODER I			139	PW	
	216-01-6120 1 1 1 1 T P 76 YRS. MONTHS DAY'S HOURS MIN. NO							8. BIRTHPLACE (State or Fo Country) MARYLAND				
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY SINAI HOSPITAL BALTIMORE								OF DEATH	A		
ည် မ	RESIDENCE OF DECEDENT								104	INSIDE CITY	,	
	MARYLAND N/A BALTIMORE						100	YES 2				
FUNERAL	5402 PRICE AVE.	100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN O 21215							US/			
E	11. MARITAL STATUS 1 Never Married 2 X X X X X X X X X X X X X X X X X X	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 14. Hever Married 2 X Married 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 16. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 17. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14.) 18. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14.)						Black, Whi Specify:	merican Indi	en,		
	15. OECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U	SUAL OCCUPATION done during me	ON set of working	16	b. KIND OF BUS	INESS/INDUST		ATTTT		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Me. Do NOT use CLEF	retired.)	or or working		u.s. cu	STOMS	DEPA	RTMEN	r .	
	17. FATHER'S NAME (First, Middle, Last) SAMUEL	STE	INBERG		18. MOTHER'S N	AME (First,	Middle, Maiden	Sumame)	BASKI	N		
TO BE	190. INFORMANT'S NAME (Type/Print) MRS. YETTA	STEINBER	G 5402	PRICE A	Number or Rural	Route Nur	nber, City or Yown	21215	de)			
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		PLACE AND DATE OF STATE		10 OA	TE 20c. LOC	CATION — City	or Town, S	tata			
	21. SIGNATURE OF FUNERAL SERVICE LICE		ARLINGTON		AMUNO-		12-1995	-DALII	MORE	, PID		
}	+ allerou	e Leve	noon	SOL I	EVINSON DEISTER	& BI			(ODE	MD 2	1015	
	23. PART I. Enter the disesses, or co ahock, or heart fallure. Li IMMEDIATE CAUSE (Finel disesse or condition resulting in death)	Pheum	sch lina.		de of dying, au	ch ss ca	rdiac or respli	atory arreat		Approxim Interval B Onset and	etween	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERIVING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
EDICAL	PART II. Other significent conditions	contributing to deeth be	ut not resulting in	the underlyin	g cause given in	Part I.	24a. WAS AN PERFORE	MEO?	COM! OF D	PLETION OF C	TO	
Σ	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	ПИОГ	UNCERTAI	ПИ			1 🗆	YES 2	10	
X	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		OTTOLKIA				_			
ă	1 YES 2 NO	NOSPITAL: 14 Inputient 2 ER/Outpi		OTHER:	e 5 🗆 Rasidence	6 🗆 Oth	er (Specify)					
PHYSICIAN	27. MANNER OF DEATH 1 A Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ			SCRIBE HOW IN	JURY OCCUR	ED			
2 Accident 28s. PLACE OF INJUSY At home form street feeting office.												
COMPLETED		AN: To the best of my knowle										
	2 MEDICAL EXAMINER:	On the beals of axamination	and/or Investigation,	in my opinion, o	eath occured at the		a and place, and	due to the ce			lated.	
2 2	38. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	H YEM 277/Type, F	(nt)	AS2402	321]	59923	▶ Oct	ober	10,10	195	
	31. DATE FILEO (Month, Day, Year)	Kc Sla	RITY	ey,	51	na	nd)-	215	017	al		
	OCT 1 7 1995 12	32 REGISTRAR'S MON	M				-		ı			



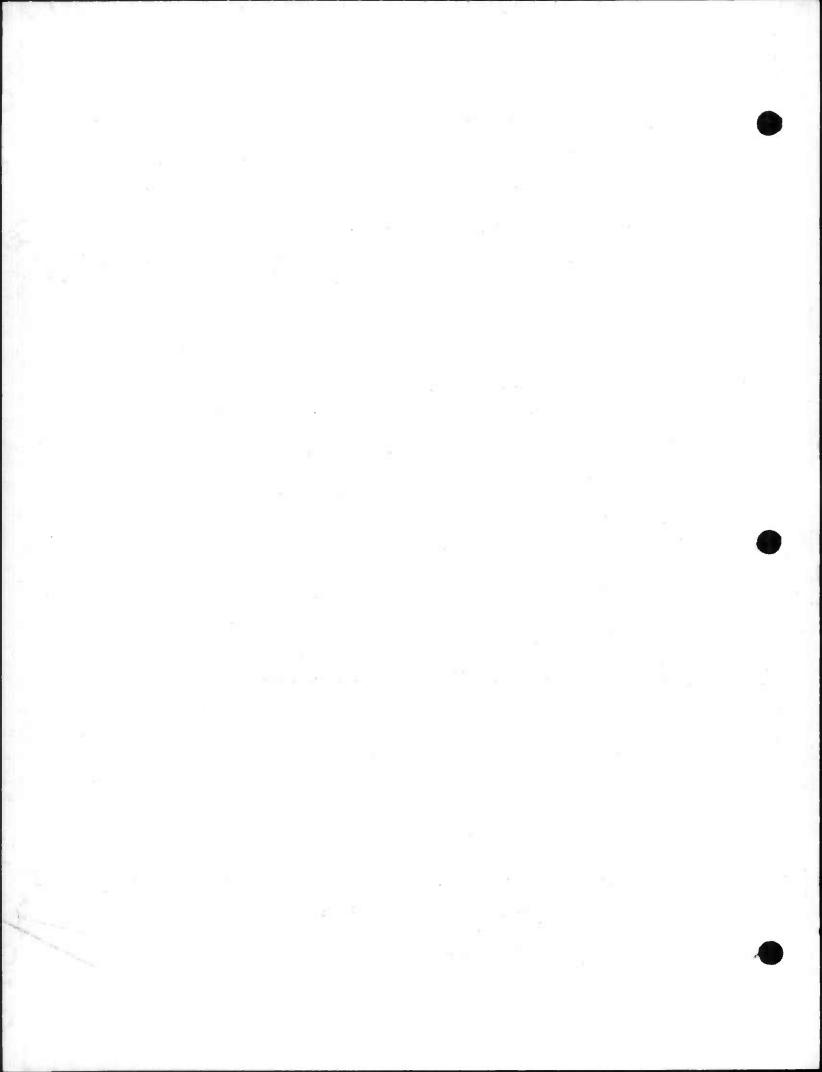


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_		4. SOCIAL SECURITY NUMBE		5. SEX 1 M 2 X F	8. AGE (In yrs 86	. last birthday) YRS.	IF UNDE MONTHS	DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF (Month). March	Day, Year)	1909	S. BIRTHPL Country) Mary	ACE (State or Foreign									
2, 3 should	BY FUNERAL DIRECTOR	96. FACILITY NAME (If not Institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF Baltimore N/A																						
if. Pages 1,		nesidence of deci-	10c. CITY, TOWN OR LOCATION Baltimore							od. INSIDE CITY LIMITS? YES 2 NO														
nsit permit.		100. STREET AND NUMBER 201 Doris Avenue 202 21225							S.A.	AT COUNTRY?														
5-0020 nding physician. is the burial-transit		11. MARITAL STATUS 1 Never Merried 2 N 3 Widowed 4 Divorce		12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2	NO	13.	Il yes, sp		n, Mexice	IIC ORIGIN? n, Puerto Ric			14. RACE -	American Indian, white, etc. White									
or atte	LETED		DENT'S EDUC highest grade of			Give kind of the Do NOT L	work done se retired.)	during mo	ON ist of working	9		of Bu	ISINESS/INDU	ISTRY	WIII OC									
LAND 2 the hospital detached for	COMPL	17. FATHER'S NAME (First, Mid		an at ant			lakei		18. MOTH	_	ME (First, Mic	idle, Maiden	Sumame)	- \										
MARYL retained by 5 should be notified at	TO BE	19a. INFORMANT'S NAME (Typ	oe/Print)	-	Macie	196. MAJLING	G ADDRES	S (Street e	and Number		Route Number	City or You	nknowr	Code)										
y be	Ţ	T	Ţ	DOFOTRY GI 20e. METHOD OF DISPOSITIO 1 X Burlel 2 Cremellon						SITION (Na	ame of		DATE	20c. LC	Mary		21090 , Stata							
Tectic de 6					4 Donation 6 Other (S	Specify)		Gle	n Have	22.	NAME AN	ND ADDRES	S OF FAC	CILITY				Maryland						
BALTIN after death, Pag by the funeral of moval. cal examiner		George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225																						
with the hours after peter filled in by the tremovement, the medical	snock, or heart tallure. List only one cause on each line.									Approximata interval Between Onset and Death														
OX 6876 be executed sician and comrior to burial, contrammatic events.	ATION	Sequentially list condition if any, leading to immediate the condition of	ntielly list conditions, leading to immediate Due to (or as a consequence of)								10days.													
P.O. BC th certificate ending physic Hygiene price or other tr	MEDICAL CERTIFICATION		cause, Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in death) LAST		DUE TO (OR AS A CON	ISEQUENCE O	ryal	fen	<i>J10</i> 36					· · · ·	144.								
RECORDS, requires that the dear een signed by the att of Health and Merita shows any Injury.						: MEDICAL	: MEDICAL					- 10	Coronary Leav	dist	dise	ne;	PU	0	Con	gest	1)2	_ ,	4e. WAS AN PERFOI	RMED7
N. The law ficate has by State Dept.	SICIAN	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		LACE OF DEA		only one)	JUNC	ERTAIN	101													
PHYSICIA this certif with the	PHY	1 YES 2 5 NO 27. MANNER OF DEATH 1 Natural 5 P	ending	1 Inpatient 2 28e. DATE OF II (Month, Day	NJURY	28b. TIN	4 🗆 Nu	28c. INJ WO			6 Other (INJURY OCCU	JRED										
OR ATTENDING I DIRECTOR: After hours after death Item 28 is man	TED BY	3 Suicide 8 C	2 Accident 3 Suicide 8 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, building)							e Number,														
= 25 B	COMPLETI			AN: To the best of m											nd manner as stated,									
TO THE HOSPI TO THE FUNEF be filed within	TO BE	29b. SIGNATURE AND TITLE O		buse s	INFF	_			29c. LICE 752	NSE NUM	6143	7	≥ OC	signed (M	onth, Dey, Year)									
()		30. NAME AND ADDRESS OF F MUHA M M (1) 31. DATE FILED (Month, Day, Ye	O N :	FIRO2 32. REGISTRAR	HARP	30 R /	. Print) HOSI	TA	LG	ENT	TER.	BI	LIIM	ORE	r11,95									
, /	OCT 1 71995 Julius Parks																							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



3. TIME OF DEATH

REG NO

2. DATE OF DEATH

D19668

R.M. SHAH. MD. 10706 Reisterstand RP. OWINGS MIV, MD. 21117

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after in	FBAI DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jalia Brest Par Contact

YEAR Carolyn Kathryn Trainer 11:30 a Oct. 16,1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Dev. Year)
June 17,1907 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 88 170-40-0712 1 M 2 XF Pennsylvania Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH 8704 Green Lane Randallstown Baltimore DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Md. Baltimore Randallstown 1 YES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8704 Green Lane 21133 U.S.A. use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cubsn, Mexican, Puerto Rican, etc.)

1 YES YN NO Specify: FORCES? 1 YES 2 1 Never Married 2 Married Specify BY 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only his st of working (Give kind of work done life. Do NOT use retired.) Š Elementary/Secondery (0-12) College (1-4 or 5+) Housewife Homemaker detached once. 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) 17. FATHER'S NAME (First, Middle, Last) Stanley D. Peters Bertha M. Ruff page 5 should be Ħ notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Marlene Trainer 315 Central Ave., Glyndon, Md. 21071 pe 20s METHOD OF DISPOSITION
1 M Burlel 2 Cremetion 3 Removal from State
4 Donetion 6 Other (Specify) 20c. LOCATION - City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must director, Parryville Cemetery Oct. 19,1995 Parryville, Penna. 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY 21117 Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, medical 23. PART f. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. interval Between INFARCTION Onsat and Death IMMEDIATE CAOSE (Final the diseese or condition MYOCARDIAL cremation, TWO HOURS resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) burial, other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 If any, leeding to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 Mental injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL and Arteno-Scierone Cardio-vancular AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 140 Health a OF DEATH? Shows 1 TYES 2 NO 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO YUNCERTAIN PHYSICIAN: Dept 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State EXAMINER? HOSPITAL: OTHER: HOME 1 | Inpatient 2 | ER/Outpatient 3 | DOA (FROUP 8 Other (Specify) 4 Nursing Home 5 Residence the 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 28c. INJURY AT WORK? Jeath with the 1 Natural 5 Pending м 1 YES 2 NO BY death Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 09 COMPLETED after 28 i 4 Homicide hours a Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 32 = TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) end menner as steted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

10-17-95

24 hours after death. Page 6 may be retained by the hospital or attending physician.	D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with metal hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF M							MENTAL HYGI REG.				
	1. DECEDENT'S NAME (First, Middle, Last)				ERTIFICATE OF DEATH			-	2. DATE OF DEATH 3. TIME OF DE			3. TIME OF DEATH	
DIRECTOR	THELMA	LQ	TURLEY			ΞΥ	T/ MONT				4:42 P.M		
	4. SOCIAL SECURITY NUMBER	5. SEX	t birthday)	IF UNDER	YEAR IF UNDER 24 HRS.		24 HRS.	7. DATE OF BIRTH 8		8. BIRT	HPLACE (State or Foreign		
	196-18-1852	1 🗆 M 2 💢 🖟	72	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept. 3	1923	Pen	nsylvania	
	9a. FACILITY NAME (If not institution, give street and number)				9b. CITY,	TOWN O	WN OR LOCATION OF E				JNTY OF	Y OF DEATH	
	UNIVERSITY S.T		BALTIMORE CITY N						N/A				
	RESIDENCE OF DECEDENT												
뿐	Maryland Baltimore			10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL D				Timonium									
	10. STREET AND NUMBER 17 Killala Ct.			101. ZIP CODE 21093					10g. CITIZEN OF WHAT COUNTR				
5	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 FORCES?						city Cuba	n, Mexica	, Puerto Ricen, etc.	IGIN? (Specify Yan or No— 14. rto Rican, etc.):		. RACE — American Indian, Black, White, atc.	
B							Specify	olfy.			Specify: White		
0	15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY												
	(Specify only highest grade completed) (0			Give kind of work done during most of working e. Do NOT use retired.)				100000000000000000000000000000000000000	Control of Property Control				
절	12				łomemaker				Own Home				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0			18. MOTHER'S NA				ME (First, Middle, Malden Surname)				
BEC	Emerson S. Kirl	K					L	_ulu	Weber	Weber			
	19e. INFORMANT'S NAME (Type/Print)		.190	b. MAILING	ADDRESS	(Street a	nd Number	or Rural F	loute Number, City or	Town, State, 2	'lp Code)	ė	
5	William B. Turle	ey		17 K	illala	Ct.	, Ti	imon	ium, MD	21093	3		
	20a. METHOD OF DISPOSITION	nord from State	20b. PLACE						DATE 20c	LOCATION -	- City or 1	Town, State	
Į.	1 Burial 2 Cremation 3 Rem		Gree	enwo					/18/95	Indian	a, F	PA	
223	21. SIGNATURE OF PUNERAL SERVICE-LI	22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home											
1	Lowell	1. Lemmo	in	an						Timoni	ium	MD 21093	
	21 PART L Enter the diseases, or	The second secon		ath. Do	not enter	the mo-	de of dvi	ng, auc	a Ru.,	apiratory a	rrest.	Approximate	
	shock, or heart fallure.	List only one car	se on each ilns	1.							CIVAT.	interval Batween Onset and Death	
	iMMEDIATE CAUSE (Final disease or condition		-	1	111	7	-					Onset and Death	
	resulting in death)	DUE TO	(OR AS A CONSE	DUENCE C	-	Nu							
z		. V)								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE C	F):								
S	cause. Enter UNDERLYING CAUSE (Disease or injury	c											
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	PART II. Other eignificant condition	na contributing to	death but not i	rasulting	in the un	darlying	cause o	given in	Part I. 24e. WAS	AN AUTOPS	7 24	b. WERE AUTOPSY FINDINGS	
CAL						ia unwanging cause given in rait i.				PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
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AN	25. WAS CASE REFERRED TO MEDICAL	KIBUIE IO CA			TH (Check	-) OIAC	EKIAII	10				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER	t:	-	F-27 F-05					
¥	27. MANNER OF DEATH	1 Inpatient 2xy ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED											
1	1 Natural 5 Pending (Month, Day, Year)			IN.	INJURY W			27€rp	Dense of AM Frenck By				
ВУ	2 M Accident Investigation 3 Suicide 6 Could not be determined See PLACE OF INJURY — A1 home building, etc. (Specify)				/ -			().5	261. LOCATION (Street and Number or Rural Route Number,				
9								CRANGROK PO COLKEYSNUE					
COMPLET	no. certifier												
	CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
8	A									r, end due to			
H	296. SIGNATURE AND TITLE OF CERTIFIER							ENSE NUI		29d. DATE SIGNED (Month, Day, Year)			
2	20 HAME AND ADDRESS DA CORDO							.C.	C.M.E. OCTOBER			14,1995	
	111 Penn Street, Baltimore, Maryland 21201												
	31. DATE FILED (Month, Day, Year) OCT 1 71995	. I sa protern	II.	T Pe	enn :	otro	eet,	Ва	Ttimore	, Ma	ryla	and 21201	
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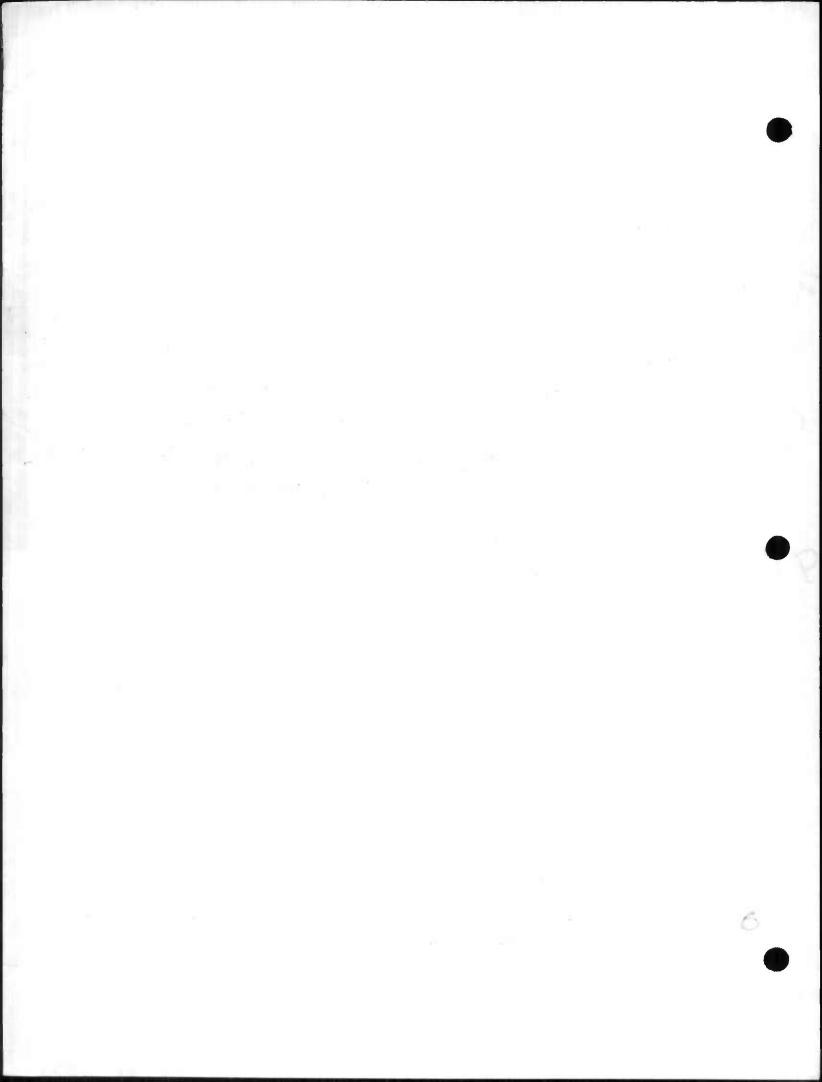


BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

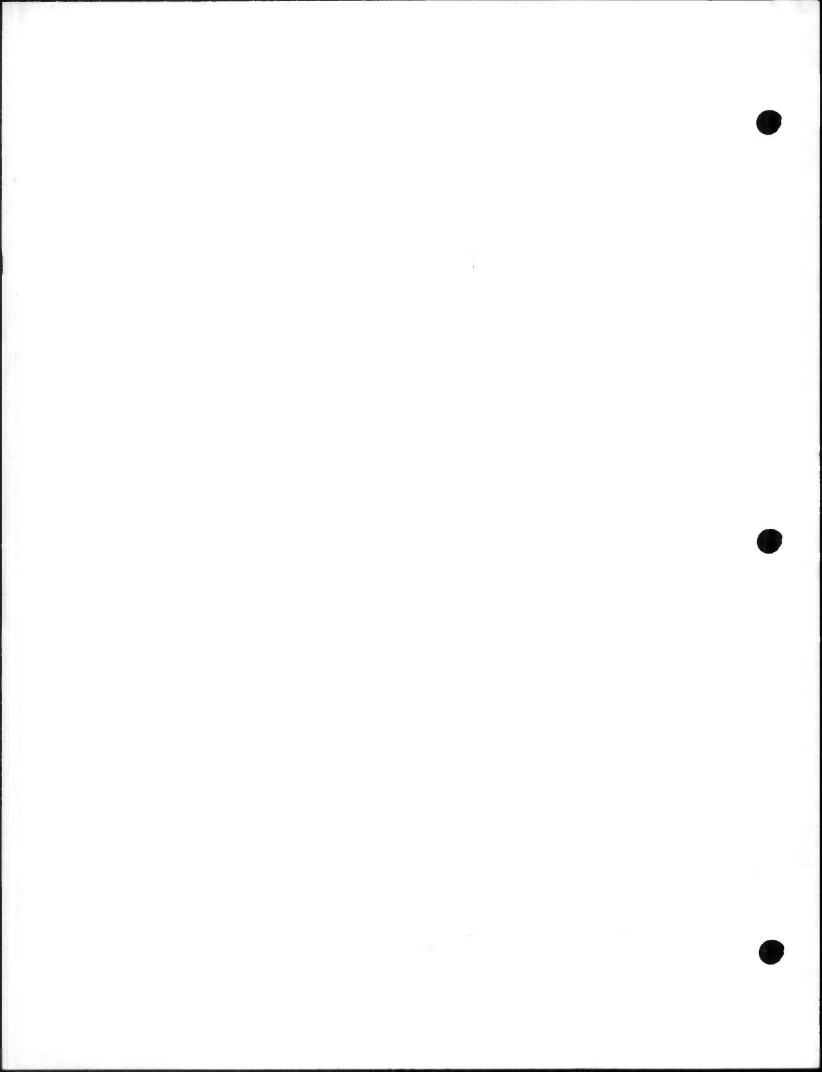
T 0 T	-510 ITEMS: 23 PART	I, 27, 28a-f, PE	R MEO FILI	M G-728	3 10/27/95 t	.t	2) 31130		
	REGISTRAR	STATE OF MARYLAND	/ DEPARTME			REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest) CLYDE M		JR.		2. DATE OF DEATN OCT . 11, 1995 4:35 P. M					
TO BE COMPLETED BY FUNERAL DIRECTOR	216-54-7414	5. SEX 6. AGE (In yrs. I	YRS. MONT		HOURS MIN.			6. BIRTNPLACE (State or Foreign Country) MARYLAND		
	9s. FACILITY NAME (# not institution, give street and number) 2277 REISTERSTOWN RD. RESIDENCE OF DECEDENT			LTIM	OR LOCATION OF DE	ATN	OF DEATH			
	MARYLAND 106. COUNTY	10c. CITY, TOY		E CITY			10d. INSIDE CITY UMITS? 1 X YES 2 NO			
	2277 Reisterstown Rd.			1	21215		U.S.	OF WHAT COUNTRY? A.		
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4VX Divorced	ARMED () NO	If yes, s	CENDENT OF NISPAN pecify Cuben, Maxicas S 2 X NO Specify	IIC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	RACE — American Indian, Black, White, etc. Specify: BLACK				
	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	Give kind of work of the Do NOT use reting	done during ri ired.)	nost of working	State of Maryland					
	17. FATNER'S NAME (First, Middle, Last) Clyde M. Tatum Sr.				Roveni	ME (First, Middle, Malden				
	19a. INFORMANT'S NAME (Type/Print) Rovenia Tatum	3				Route Number, City or Tow Il timore, I	Marylar	d 21215		
	20s. METNOD OF DISPOSITION 1 Burlal 2 (\(\) Cremation 3 Ramoval trum state 4 Donetion 5 Other (Specify)			lace) IATORY		DATE 20c. LOCATION — City or Town, State 10/12 Baltimore, Maryland				
	22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
	PART II. Other significant conditions	t resulting in th	ne underlyi	ng ceuse given in	Part I. 24s. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO			
IAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
HYSIC										
BY PI	1 Natural 5 Pending 2 Accident Investigation	Natural 5 Pending (Month, Day, Year) Accident 10-11-95 FOUND			YES XX NO	SUBJECT INGESTED DRUGS				
COMPLETED	3 Sulcide 4 Homicide 8 XX bould not be datermined 28a. PLACE OF INJURY — At home, farm building, atc. (Specify) FOUND AT			_	ica	City or Town, State BALTIMORE,				
	29a. CERTIFIER (Check only one) 1 CERTIFVING PNYSICIAN: To the best of the knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2XXMEDICAL EXAMINED: On the basis of summer and place, and due to the cause(a) and menner as stated.									
TO BE C	Ohio BIOGRATURE AND TITLE OF GRATIEIS			O.C.M			SIGNED (Month, Day, Year) 2. 12, 1995			
ř	MARIO F. COLUMN AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 111 Penn Street, Baltimore, Maryland 21201									
	31. DA OCT 1011 7 1995 Ju	32. REGISTRAR'S SIGNATURE					-			



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	_
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Mickelle Last) 2. DATE OF DEATN 3. TIME OF DEATH YEAR Francis Varsha1 995 October | 3:35 A. 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign 172 18 1030 1 X M 2 - F 81 Feb. 26, 1914 Pennsylvania Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Anne Arundel General Hospital Annapolis Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Glen Burnie 1 YES 2 1 NO permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 313 Hospital Drive 21061 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 X YES 2 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: White 0 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPLI Laborer 8th Drum and Barrel Maker 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 7 John Varshal Emma Rayha BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy Matuch 5651 Broadview Road Parma, Ohio 44134 Page 6 may be Pe 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director. Cedar Hill Cemetery 4 Donation 5 Other (Specify) 10/18 Baltimore, Maryland вхатіпег 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. George J. Gonce Funeral Home P.A. manirousky Long n by the removal. 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. medical Approximata filled in interval Between 8 IMMEDIATE CAUSE (Fine) **Onset and Death** cremation. the disease or condition resulting in death) OF THE LUNG ARCINOMA npletely 1 O MONTHS event, DUE TO (OR AS A CONSEQUENCE OF) and con bunal. traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING ending physician a l Hygiene prior to CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa reaulting in death) LAST 0 the atter Injury, PART il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY by and PERFORMED? shows any signed Health a 1 TES 2 NO 1 YES 2 NO been 1. of 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem certificate h 1 TES 2 NO OTHER: 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF INJURY 28c, INJURY AT 28d, DESCRIBE NOW INJURY OCCURED this with marked, 1 Natural М 1 YES 2 NO BY After Investigation 2 Accident DIRECTOR; An hours after de item 28 is r 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be detarmined COMPLETED 4 Homicide TO THE HOSPITAL DR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If item 2 29s. CERTIFIER (Check only 1) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the films, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ME 03070 13/95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT D RIDGELY 5001 600 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	2 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	I item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF OEATH FLORENCE WEINBERG OCTOBER 10 1995 5:45pm М 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 1 🗆 M 2 🖳 🗜 MONTHS DAYS HOURS 219-12-5567 JUNE 14, 1913 MARYLAND 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 11 SLADE AVE, APT. 407 BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 YES 2 NO BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11 SLADE AVE, APT. 407 21208 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puarto Ricen, atc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES Specify: BY 3 🔀 Widowed 4 🗌 Divorced WHITE ED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Щ Elementery/Secondary (0-12) College (1-4 or 5 +) COMPL 12 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Meiden Surneme) **JACOB** WINER KAGAN BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. BESS SALKIN 11 SLADE AVE, APT. 609 BALTIMORE, MD 21208 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1

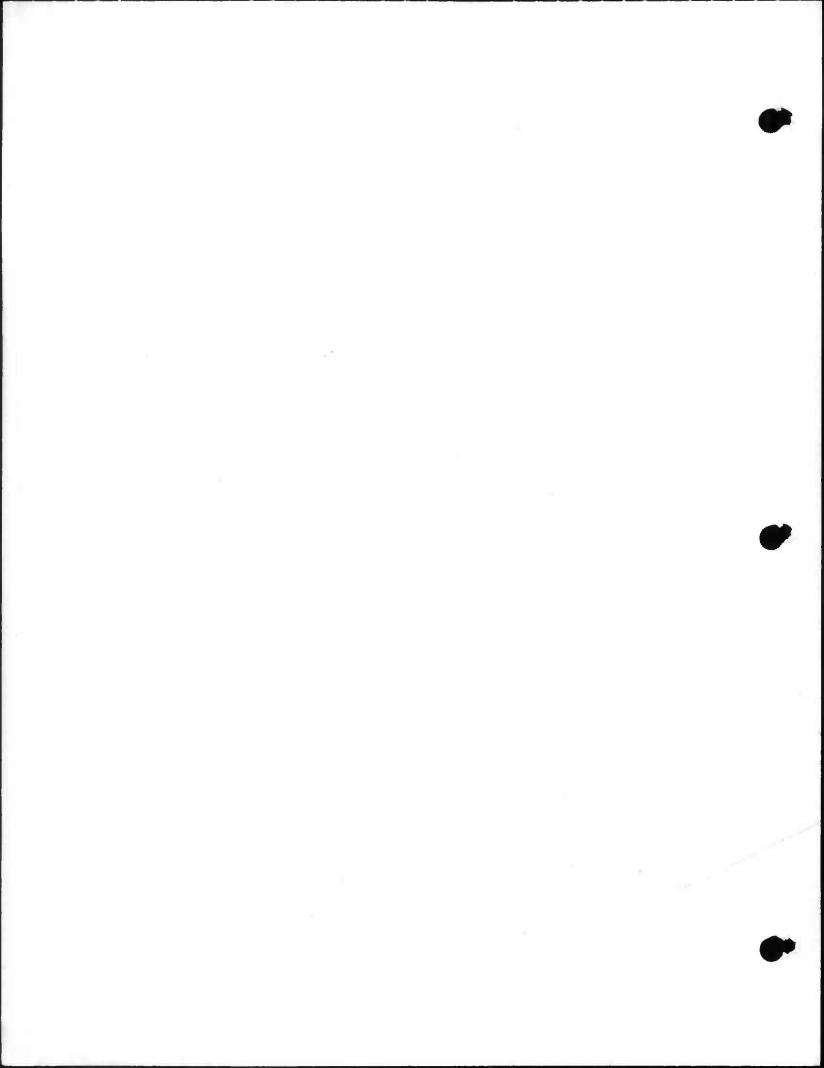
 Buriel 2 ☐ Cremetion 3 ☐ Removal from State OHEL YAKOV BETH ISRAEL - 10-12-1995- BALTIMORE, MD 4 Donetion 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximeta Interval Between Onset and Death IMMEDIATE CAUSE (Final diseese or condition RESPIRATORY
DUE TO (OR AS A CONSEQUENCE OF): FAIULRE resulting in death) RENAL CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO 5£0 53 COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [PHYSICIAN: 28. PLACE OF DEATH (Check only 25. WAS CASE REFERRED TO MEDICAL EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) HOSPITAL: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident 5 Pending м 1 YES 2 NO BY Investigation 28a. PLACE OF INJURY — At homa, farm, atreet, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner ea stated. 29a. CERTIFIER 2 MEDICAL EXAMINER: On the b ation end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. MATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 38

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after fourth. Page 5 should be detached for use as the burist-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remover must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND DEATH		HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Lest)	th				2. DATE OF MONTH			EAR	TIME OF DEA	A M	
	082 01 3922	□ M 2 🗗 F	M 2 F 86 YRS. MONTHS DAYS HOURS MAIN. (Morth, Day, Ver) Co. March 8,1909 Ne								Foreign	
TOR	9e. FACILITY NAME (# not institution, give street Hopkins Bayview Me				altimore			9c. COUNTY OF DEATH N/A				
FUNERAL DIRECTOR	10e. STATE 10b. COUNTY	N/A	10c. CITY, TO	OWN OR LOCAT		timor	e			INSIDE CIT		
IERAL	100. STREET AND NUMBER 14 A Cross Keys R	d.,		10f	21210			10g. CITIZEN OF WHAT COUNTRY? United States				
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2V NO	If yes, sp	ENDENT OF NISPA ecity Cuban, Mexico 2 X NO Specifi	en, Puerto Rici	Specify Yee an, etc.)	or No- 14	RACE — Black, W Specify:	American Ind White, atc.		
COMPLETED		ION ripleted) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mo ired.)	N st of working	16b. K		INESS/INDUS				
OMP	12 17. FATHER'S NAME (First, Middle, Last)		Sec	retary	18. MOTNER'S NA	ME (First, Mich			it or	rganiz	ation	
BEC		В	urnham		Lillian		o.o, marcon	os neme,	Howe	2		
2	Dr. James Wirth				nd Number or Rural							
	20a. METHOD OF DISPOSITION	200	PLACE AND DATE OF DI		s Rd., E	DATE	-	ATION - CIN	2121(
	1 Buriel 2 Cremation 3 Removal 4 Donation 6 Other (Specify)		reen Mount	Crema			Ba	ltimo	ce, N	1D		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	usun		CAFA 8717	o adoress of Fa Stephen Green Pa	D. Lol	e Dr	Ra1+i	more	MD 2	1206	
AL CERTIFICATION	23. PART I. Enter the diseases, or comeshock, or heart failure. Liet IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or the conditions of the cause of the conditions of the cause of th	DUE TO (OR AS A DUE TO (OR AS	CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF): CONSCOUENCE OF):	nkno menti	wn a/C1	/ A is	ia. WAS AN	WITOPSY	24b. WE	Approximinterval Bionast and Constant C	Batween d Daath	
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H	27. MANNER OF DEATN 1	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	M 1 Y	RK?	28d. DEŞCR	IBE NOW IN	JURY OCCUR	ED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, strest			28f. LOCATH City or 1	ON (Street allown, State)	nd Number or	Rural Route	Number,		
COMPLE				eath occurred at the time, data and place, and due Investigation, in my opinion, death occured at the				ue to the cause(s) and manner as stated, he time, data and place, and dua to the cause(s) and man				
IO BE	29b. SIGNATURE AND TITHE OF CERTIFIER		29c. LICENSE NUM D437			UMBER 732 ≥ 10/ Circle 3a1+ m>			ONED (Month, Day, Year)			
	Michael Harper	M. D. ST	ATH (ITEM 27) (Type, Print	v 80	igview (? rile	3.	1 + m,	> 2	rzzy		
	"OCTI 71995" Juli	34 RECISTRAR'S ON	TURE		·····							





3. TIME OF DEATN 9:45

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

L DECEDENT'S NAME (First, Middle, Last)

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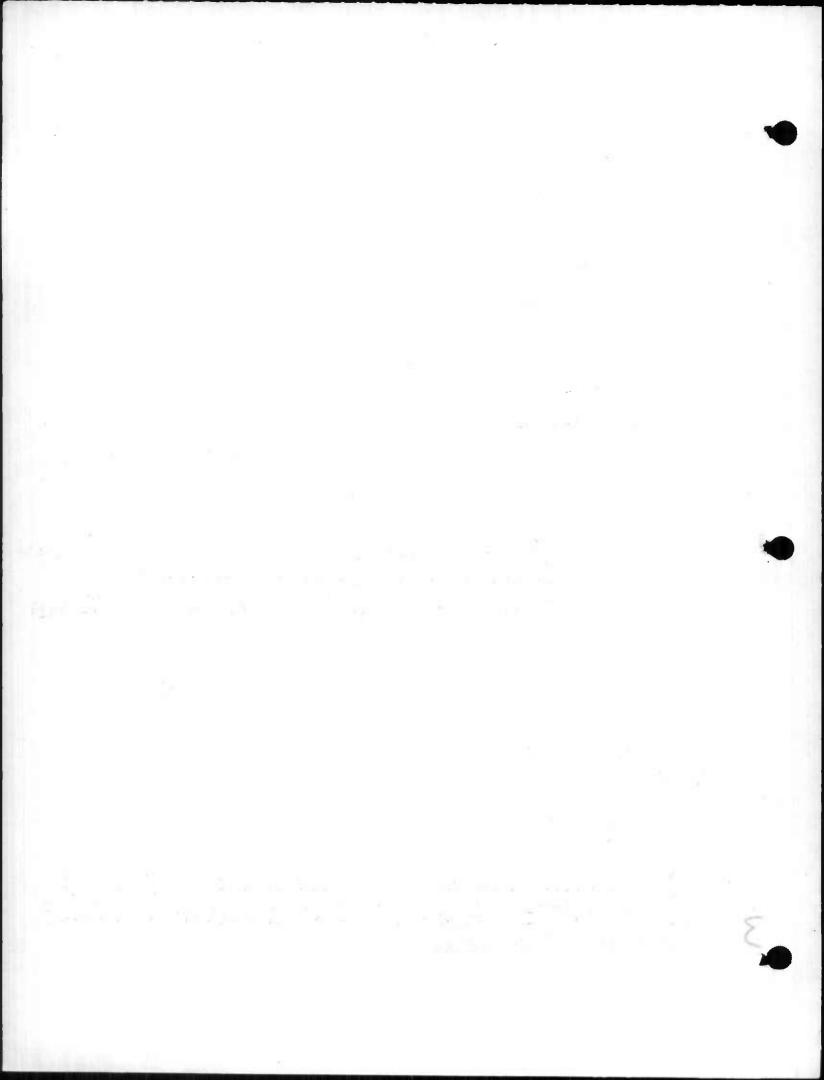
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DIVISION OF VITAL RECORDS, P.O. BOA SOLON	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after
5	OR.
	PITAL

E SOCIAL SECURI	11 manual	5. SEX	6. AGE (In yrs. last		IF UNDER 1		IF UNDER		7. DATE C				PLACE (State or Foreign
220-30	-4381	1 🗆 M 2 📆 💢	83	YRS.	MONTHS E	DAYS	HOURS	MIN.	Jul	y 15,	19	12	" MD
9a, FACILITY NAM	Se. FACILITY NAME (If not institution, give street and number)							ON DF DI	EATH		Oc. COUNTY OF DEATH		
	Secour	s Hospi	ta1		E	3a1	timo	imore n,					1
10a. STATE	10b. COUN	TY		10c. CIT	Y, TOWN OR	LOCAT	ION						10d. INSIDE CITY
MD		n/a			Ва	alt	imor	re					LIMITS?
100. STREET AND	NUMBER					10t.	. ZIP COOE				10g. CIT	IZEN OF W	VHAT COUNTRY?
2110	Fairmo	unt Ave	•				21	122:	3				USA
11. MARITAL STATE 1 Never Marrie 3 Wildowed	d 2 Married	FDRCES?	NT EVER IN U.S. AR 1 YES 2 X WAR OR DATES		If y	yes, spe		n, Maxica	n, Puerto R	? (Specify Yes icen, etc.)	or No-	14. RACE Black Speci	E — American Indian, k, White, etc.
	16. DECEDENT'S ED	UCATION			USUAL OCC				16b.	KIND OF BUS	SINESS/IN	DUSTRY	
Elementary/Sec	pecify only highest grad condery (0-12)	College (1-4 or 5	life	Do NOT us	work done dui se retired.)	ring mos	st of workin	g					
8t	h		D	omes	stic						Home	emak	cer
1	E (First, Middle, Lest)						18. MOTE	HER'S NA	ME (First, A	liddle, Maiden	Sumame)		
	on I. R	chards		200.00				_		Bake			
19a. INFORMANT'S	L. Ric	harde								er, City or Town Balto			21222
Amos		larus			OF DISPOSIT			A	OATE			City or To	21223
1XX Buriel 2	Cremation 3 Rei	moval from Stata	cemetery, cre	matory or o	noria	1	Pk		1				stown, M
	FUNERAL SERVICE L	ICENSEE	- KIIIG	1101	22 NA	AME AN	NO ACCRES	SS OF FA	CILITY				
1	remes		Wat	~						& So t. Ba			eral Home
23. PART I. Fat	the diseases, or	complications th	et caused the de	eth Do		_							D 21217 Approximata
afric	ck, or heart failure											,	
		7	use on eech line),					AT MM CMTC				
IMMEDIATE CA		Pa	on eech line		0 ^				JI MM CMIC				
IMMEDIATE CA disesse or con resulting in dea	dition	Pre	ome	M									Interval Betwee
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disesse or con resulting in de	at conditions,	Pre Due To	O (OR AS A CONSE	OUENCE O	he	2	iel	0)		onse	ion	whe	3day
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disesse or con resulting in de	at conditiona, to immediate NDERLYING or injury	DUE TO DUE TO DUE TO	O (OR AS A CONSE	DUENCE D	SCI	w w	jel	اه		onse	ion	Ly c	3day
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disesse or con resulting in delication in de	at conditiona, to immediate NDERLYING e pr injury vents ath) LAST significant conditions to provide the provided to prince the provided to prince the provided to prince the provided to	DUE TO DU	O (OR AS A CONSEI O (OR AS A CO	DUENCE OF DEAL 26b. Tile No.	In the und ES N NTN (Check on OTHER: 4 Nursh ME OF JURY M atreet, tector	ing Horn 28c. INJ WO 1	g cause g UNC UNC TORK? YES 2 a and place a and place a and place	given in	Part I. 6 Other 28d. OES 281. LOC City a to the cause time, data	24a. WAS AN PERFOR 1 YES 2 (Specify) CRIBE NOW I	AUTOPSY SMED? INJURY OCH and Number	24b CCURED or or Rural II ated, the cause(e	Onset and Dec
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DNMN-16 Rev 1/89



TO THE HOSPITAL DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunlat-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT	OF HEALTH
REGISTRAR	CERTIFICATE	OF DEA

	1 - STATE OF MARYL REGISTRAR	AND / DEPARTM			MENTAL	HYGIENE REG. NO.					
	1. DECEOENT'S NAME (First, Middle, Last) VANESSA WHY LEA	un <	·		2. DATE O	F DEATH	地道	AR	IME OF DEATH		
		(In yrs. lest birthday) IF to MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month).	F BIRTH Day, Year)	8. 8		CE (State or Foreign		
DR	99. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL	96.		MORE CIT	ATH		9c. COUNTY N/A				
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		WN OR LOCATI					INSIDE CITY			
	MARYLAND N/A 100. STREET AND NUMBER	BAL	TIMORE 101.	ZIP CODE			10g, CITIZEN	OF WHAT			
FUNERAL	2517 Talbot Road 11. MARITAL STATUS 12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED		21216 ENDENT OF HISPAN city Cuben, Mexicar				S.A RACE — / Black, Wh	American Indian, lite, etc.		
B	3 X Widowed 4 Divorced IF YES, GIVE WAR OR D	ATES	1 TYES	2X NO Specify				Specify			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12th grade 12th grade	180. DECEDENT'S USU (Give kind of work of life. Do NOT use reti Superviso	done during mos ired.)	N It of working			Sale:				
COM	17. FATHER'S NAME (First, Middle, Last)	Super v 130		18. MOTHER'S NAI	ME (First, Mi	ddle, Maiden S					
BE	Jesse Williams 19a. INFORMANT'S NAME (Type/Print)			Julia A	Route Numbe	r, City or Town					
٩	Pastor Julia Williams	2517 Ta		oad, Bali	timor		ryland				
	XX Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	L'AKEST DE "CI	EMETERY	1	10/1	7 DO	VER, DI	ELEWA			
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	oje		AM. C. 1 W. NORTI			JNITY	F/H			
	PART I. Enter the diseases, or complications that cause shock, or heart failure. List only one cause on a IMMEDIATE CAUSE (Finsi	ach iina.					ratory arrest	,	Approximata Interval Batween Onset and Deeth		
	disease or condition resulting in deeth) a a	CRAIST	- HE	MOME	RAAC	E					
NOIL	Sequentially list conditions, if any, leading to immediate b. ASCULTTS DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	A CONSEQUENCE OF):									
	d	but not resulting in ti	he underlying	cause givan in	Part I.	24s. WAS AN		24b. WE	RE AUTOPSY FINDINGS		
DICAL					_	PERFOR		OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE C		□ NO X	UNCERTAIN	V 🗆			1 [YES 2 NO		
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 VIII 1 Input on 2 ER/Out		THER:	e 5 🗆 Residence	6 🗆 Other	(Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Yeer)	28b. TIME OF	WO	URY AT RK? 'ES 2 NO	28d. DESC	CRIBE HOW II	NJURY OCCUR	ED	111-0		
red BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route City or Town, State)										
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of examination							ouse(e) an	d menner as stated,		
ш	29b. SIGNATURE AND TITLE OF CONTIFIER		. A	29c. LICENSE NUI					inth, Day, Year)		
TO B	30. NAME AND AGORESS OF PERSON WHO COMPLETED CARSE OF DE	EATH (TEM 27) (Type, Prir	mt)	A5240	2371	K492	00	Let	01 01995		
	Julie K That Ffre	V MT)								
	OCT 1 71995 July 2010	64									

ter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should beal.	al examiner must be notified at once.	TO BE COMPLETED BY FILINFRAL DIRECTOR
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cx, nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY DHYSICIAN: MEDICAL CERTIFICATION

_			MENT OF H		MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last) MARGARET A WILLIA	MS			2. DATE OF DEATH MONTH		sar 1400 4rm				
П	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. $254-56-2533$ $1 \square$ M $2 \square$ 5. 7		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. OATE OF BIRTH (Morith, Day, Year) 3 - 26 -	38	BIRTHPLACE (State or Foreign Country)				
TOR	98. FACILITY NAME (If not institution, give street and number) Med Pointe Cont-Care Cente RESIDENCE OF DECEDENT			ON, M	d.21921	9c. COUNTY	OF DEATH CeciL				
DIRECTOR	10a. STATE Md. 10b. COUNTY Cecil	10c. CITY,	TOWN OR LOCAT	ECK	Ton		10d. INSIDE CITY LIMITS? 1 VES 2 NO				
FUNERAL	100. STREET AND NUMBER Price Drive		101	ZIP CODE	1921		U.S.A				
B⊀	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Torvorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED	If yes, sp		NIC ORIGIN? (Specify Ye in, Puarto Rican, etc.) y:	a or No— 14.	RACE — American Indian, Black, White, atc. Specify: W Lulu				
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of wo	SUAL OCCUPATION MANAGEMENT PROPERTY PROPERTY MANAGEMENT PROPERTY MANAGEMENT PROPERTY MANAGEMENT PROPERTY PROPERTY MANAGEMENT PROPERTY P	st of working	HOSPIT		тяу				
	17. FATHER'S NAME (First, Milodia, Liest) Bill Williams				ME (First, Middle, Malde) e Keating	Surname)					
BE	19a. INFORMANT'S NAME (Typo/Print) (daughter)	19b. MAILING A	ADDRESS (Street)		Route Number, City or To	vn State Zip Co	de)				
임	Corey Swain										
	20a. METHOD OF DISPOSITION 1 Gurlel 2 Cremation 3 Removal from State 4 N Donetion 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State										
	21. SHOMESHE OF PUNERAL SERVICE LICENSEE RONALD Wade	i, Dir.					ltimore Street 21201-1559				
N	23. PART I. Enter the diseases, or complications that caused that shock, or heart failure. List only one cause on each immediate CAUSE (Finel disease or condition resulting in death) a	IINE.	UNG	CA.	2663		Approximete interval Between Onset end Deeth				
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PHYSICIAN: MEDICAL C	PART II. Other eignificent conditions contributing to death but no	ot resulting in	the underlyin	g cause given in	Part I. 24a, WAS A PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			LACE OF DEATH (C)	neck only one)						
YSI	1 Tes 2 NO 1 Inpatient 2 ER/Outpatien	t 3 🗆 DOA			6 Other (Specify)						
ВУ РН	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation	26b. TIME INJU	M 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW						
	3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and Number or Rural Route Number of Street) 28c. LOCATION (Street and Number or Rural Route Number of Street) 28c. (Specify) 28c. (
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and										
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH.	D I	Polinit)	29c. LICENSE NU	WBER 0 2 404		1GNED (Month, Day, Year) 0/68/95				
	Dr. Gary Beste 132 W. Main			, De	19711						
200	31. DATE FILED (Month, Day, Year) OCT 17 1995 July Discussion	BE A			4						
							DHMH-16 Rev 1/8				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

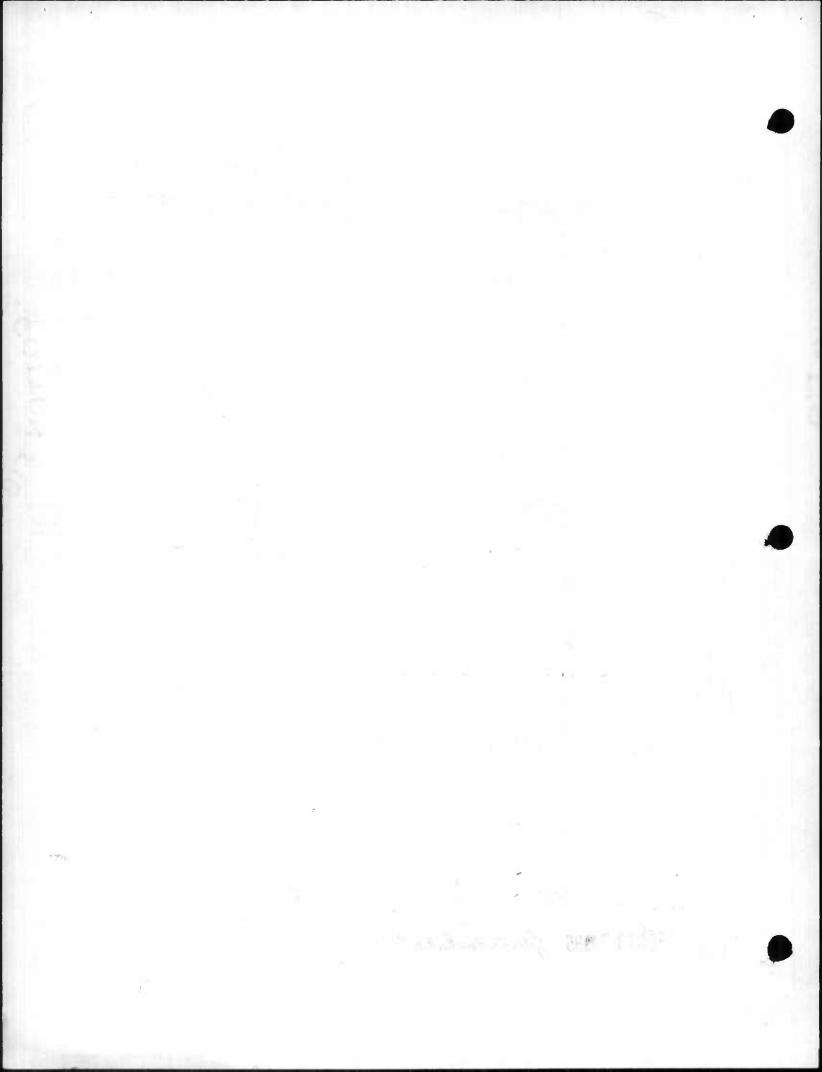
FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY MONTH D											3. TIME OF DEATH		
	Howard		Werb	cbel					OCTO	ber°	2,19	955	5:10p	
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In)			IF UNDER	1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, I	BIRTH Day, Year)		8. BIRTH	HPLACE (State or Foreign
	120 01 506	1 5067 1 M 2 □ F			9 YRS.									W York
DIRECTOR	Hebrew Home	e of		er Wa	shi			TOWN	ROCKV				nty of c	emery
	10e. STATE 10t	. COUNTY				10c. CITY,	TOWN O	R LOCA	TION					10d. INSIDE CITY
AL DI	Maryland M	Mont	gomery			Roc	kvi	-	H. ZIP CODE			100 CIT	IZEN OF V	LIMITS? 1 YES 2 NO WHAT COUNTRY?
FUNERAL	6111 Montro						,		20852			USA	A	
2	1 Never Married 2 Men 3 Widowed 4 Divorced	rled	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	20 RO	ED	- 11	yes, sp	CENOENT OF HISPA becify Cuben, Mexico 3 2 NO Specif	in, Puerto Ric	Specify Yea	or No—	Blac	E — American Indien, k, White, etc. "Ite
1	15. DECEDER (Specify only high	NT'S EDUCA	ATION completed)	10	(Give	DENT'S U	rk done d	CUPATE uring mo	ON ost of working	16b. K	IND OF BU	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)		College (1-4 or 5 +	·)		oke				In	sura	nce	Com	pany
BE CO	17. FATHER'S NAME (First, Middle, Jacob Werbe								18. MOTHER'S NA					
	19e. INFORMANT'S NAME (Type/F	Print)			19b. I	MAILING A	DDRESS	(Street	end Number or Rural	Route Number,	City or Tow	n, State, Zic	Code)	
2	Jerry Werbe	el			86	03	Pap	pas	Way, Fa	airfa	x, V	irgi	lnia	22003
	26a. METHOD OF DISPOSITION 1 St Buriel 2 Cremation 3 4 Donation 5 Other (Spe		val from State	20b. Pl Cemete Kin	TY, Crema	DDATE OF	DISPOSI	em.	Gdns.	DATE				urch,
ľ	21. SIGNATURE OF FUNERAL SE	RVICE LICE	INSEE	,					ND ADDRESS OF FA			irgi	nia	
1	MXELLUL	Mell	dull	11					gton, \			поп	ies	
	23 PART I. Enter the disease shock, or heart	sea, or co	omplications that	caused th	he deet	h. Do no						ratory an	rest,	Approximate
	IMMEDIATE CAUSE (Final disease or condition		100				7	/ -						Interval Between Onset and Death
	resulting in death)	a.		pulmonary embolus (acute) OUE TO (OR AS A CONSEQUENCE OF):										
.			fracture of lost famous								(NAV			
5	Sequentially list conditional if any, leading to immediate			JE TO (OR AS A CONSEQUENCE OF):							INDAY			
3	CAUSE (Disease or injury	c	Alzheimer's dementia							INDEF				
CERTIFICATION	that initiated eventa resulting in death) LAST	d.	COL TO (OR AS A CONSEQUENCE OF):											
- 11	PART II. Other significent c	onditions	contributing to	deeth but	not res	ulting in	the unc	leriyin	g ceuse given in	Part I. 20	Ie. WAS AN		24b	WERE AUTOPSY FINDINGS
MEDICAL										_ 1	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ										-\.				1 YES 2 NO
	DID TOBACCO USE		IBUTE TO CA							N A				
ra tolcian.	25. WAS CASE REFERRED TO ME EXAMINER? 1X YES 2 NO		HOSPITAL:				THER				0.5			
	27. MANNER OF OEATH		28a. DATE OF	INJURY		28b. TIME	OF.	28c. INJ	IURY AT	6 Other (S		NJURY OC	CURED	
	1 Netural 5 Pend 2 Accident Inves	ling Higation	9/217/9	5		8:	30a		YES 2 NO	lost	ba1	ance	, fe	ll on flo
COMPLETED	3 Suicide 6 Coule	d not be mined	280. PLACE OF building. Nursi	F INJURY — etc. (Specify) .ng H	At home	, farm, str	eet, fecto	ry, offic	•	28f. LOCATE		and Number		
	29a. CERTIFIER (Check only	NG PHYSICI	IAN: To the best of	my knowled	ge, death	occurred	at the tin	ne, date	end piace, end due				ed.	
														and manner ee stated.
	295. SIGNATURE AND TITLE OF	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mon								(Month, Day, Year)				
	4	IO. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1)00.							D07099)		100	-	11 95
	Dr. Francis							rnw	ood Roa	ad, #3	01,B	ethe	sda	,MD20817
	31. DATE FILED (Month, Day, Year)		32. REGISTRA	R'S SIGNATU		-					•			
	OCT 1 7 1995	11	dudes	Seclas	12									
	•		2115.7											DHMH-16 Rev 1/8

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH		YGIENE EG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF	DEATH

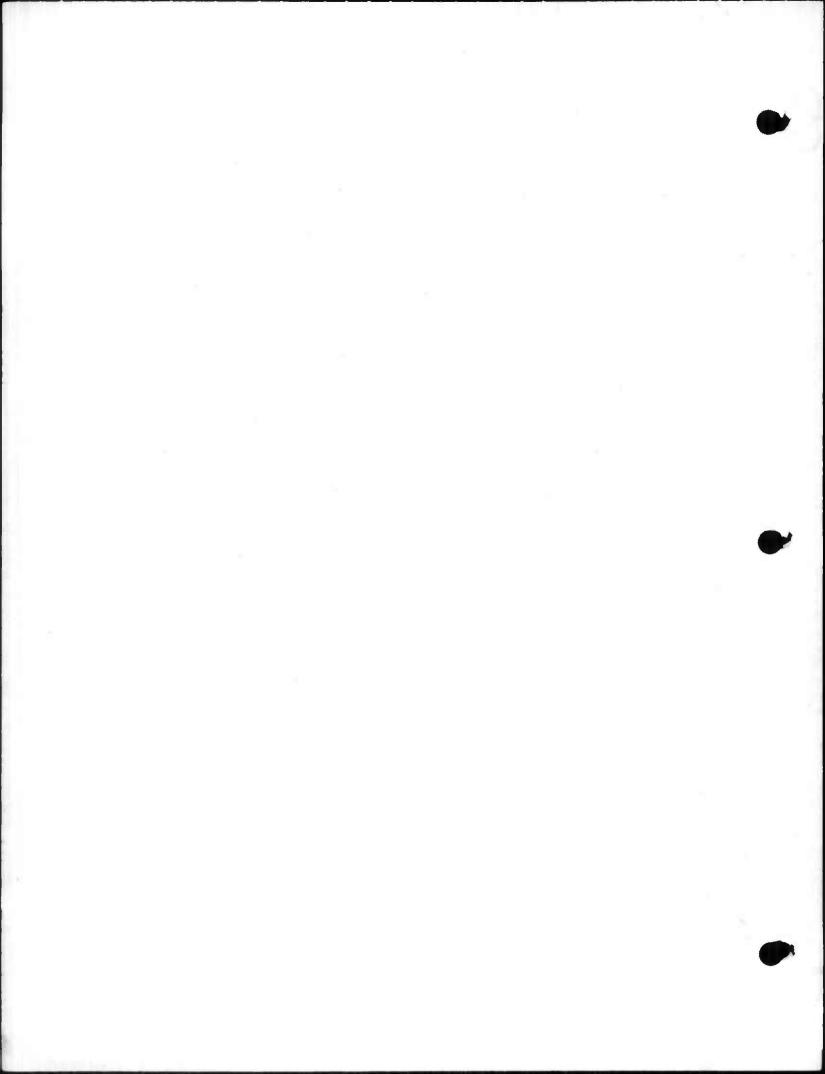
	1 - STATE REGISTRAR	STATE OF MA				TOF H E OF			MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)		- 02		IOAII		DEA	•	2. DATE O		,.		3. TIME OF DEATN
	CARLEZI	TUCHA							MONTH		12,19	YEAR	07:47A M
	4. SOCIAL SECURITY NUMBER	1	AGE (In yrs. last I	birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE O	BIRTH	7	8. BIRTNI	PLACE (State or Foreign
	213 32 2318	1 M 2 D F	60	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)	1935	Country	OHIO CHEAND
	Se. FACILITY NAME (If not inetitution, give	street end number)			9b. CIT	Y, TOWN O	R LOCATIO	ON OF D					
S S	MERCY MEDIC	AL CENTA	R		121	CTA	161	6	MO	C→AN/A			
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT							V .			1000		
E						OR LOCATI	ION						10d. INSIDE CITY LIMITS?
	Maryland N/1	A.		Ba	altin	_	ZIP CODE						1 X YES 2 NO
RA	3531 - 3rd Stre	oot-				101.	212					S.A	HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARM	ED	12	WAS DECE			NIC ORIGIN?	/Passille Ve	_		American Indian.
	1 Never Merried 2 🔯 Merried	FORCES? 1 X	YES 2 NO			If yes, spe	cify Cube	n, Mexico	en, Puerto Ri	can, etc.)	a or No-	Black	, White, etc.
BY	3 Widowed 4 Divorced	Korean		t		1 1 163	2.00 110	Specii	у.			Specif	White
E	15. DECEDENT'S EDU (Specify only highest grade	JCATION e completed)	18e, DECI	EDENT'S	USUAL C	CCUPATIO during mos	N of of weeking	~	16b, I	IND OF BL	ISINESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfo. E.	Do NOT us	se retired.)			•					
COMPLET	12th		Mai	nter	lance	e Mec					Arund	el C	ounty
	17. FATHER'S NAME (First, Middle, Last)	John Andre	r Zauch				18. MOTI		ME (First, Mi				
BE	19a. INFORMANT'S NAME (Type/Print)	John Andre						_	phie V				
2	Marilyn Zaucha					s (Street ar d St1			Route Numbe				nd 21225
	20a. METHOD OF DISPOSITION		20b. PLACE AN								CATION —	-	
	1 St Burlet 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	novel from State	cemetery, crem	atory or o	ther place	mori	al D	ark	1.0/16	20c. L	on Du	enty or to	, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	Olen	Idve	22.	NAME AN	D ADDRES	S OF FA	CILITY				
1 3	George J. Gonce Funeral Home P.A.												
	22 DATE STANKE /A	Ama Marameraturity 4001 Ritchie Hwy. Baltimore, Md. 21225											. 21225
													Approximete interval Between
	IMMEDIATE CAUSE (Finel											Onset end Death	
	disease or condition resulting in death) a. A cute Myocardul Infurction DUE TO (OR AS A CONSEQUENCE OF):											Hours	
-				LIVE O									
힐	Sequentielly list conditions, if any, leading to immediate	b	R AS A CONSEQU	IENCE O	F):								
3	cause. Enter UNDERLYING CAUSE (Disease of Injury	c											
E	that initiated events resulting in death) LAST	DUE TO (QI	R AS A CONSEQU	ENCE O	F):								
CERTIFICATION	Total and a data and Exist	d											
	PART II. Other algnificant condition	na contributing to de	eth but not res	sulting	in the u	nderlying	cause g	iven in	Part I.		AUTOPSY	24b.	WERE AUTOPSY FINDINGS
CAL	MORBID DE	SESITU								PERFD			AVAILABLE PRIOR TO COMPLETION DF CAUSE
MED	Diabetes M	ellitus									A NO		OF DEATH?
									_				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26. PL/	ACE OF D	EATN (Ch	eck only one)				
SIC	1 VES 2 NO	HOSPITAL:	R/Outpatient 3	DOA	OTHE		6 □ Re	sidence	8 🗆 Other (Specify)			
E	27. MANNER OF DEATN	28a. DATE OF IN. (Month, Day,	JURY Year)	26b. TIM		26c. INJU	IRY AT				INJURY OCC	URED	
BY	1 Netural 5 Pending 2 Accident Investigation				М		ES 2	NO					
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF III building, atc	NJURY — Al home (Specify)	e, ferm, s	street, fec	tory, office			28f. LOCAT	ION (Street Town, Stete	and Number	or Rural Ad	oute Number,
COMPLETED		11.5											
릴		ICIAN: To the best of my											
ő	2 MEDICAL EXAMINE	ER: On the basie of exam	nination and/or im	restigatio	on, in my o	opinion, de	ath occur	ed at the	time, date e	nd placa, e	nd due to the	cause(s)	end manner se stated.
BE (29b. SIGNATURE AND TITLE OF CERTIFIE	В					29c. LICE	NSE NUI	WBER		29d. OATE	SIGNEO	(Month, Day, Year)
0	Shelly L. C	pours-	M				PC	91	34		00	tober	12,1995
	30. NAME AND ADDRESS OF PERSON WA	IQ/COMPLETED CAUSE									-73		
	MERLY MEDICAL (32 St P	anl	Pla	u B	alhu	rore	- I MA				
	31. DATE FILED (Month, Day, Year)	ALLA WAUEL	SIGNATURE	41									
	0001 - 1000	The section	MANAGE.	**									



1 - FOR STATE REGISTRAR

								rico. No.				
	1. DECEDENT'S NAME (First, Middle, Last	STAN	115	1	2/18	Omas.	2. DAT	E OF DEATH	WY .	YEAR 3.	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER			/		RAMSK	///) //	90	5	7.29 P	
- 1	185-07-8797	1 M 2 □ F	GE (In yrs. le:	YRS.	MONTHS D	AR IF UNDER 24 HRS	(Mon	th, Day, Year)	1917	Country)	ACE (State of Foleign	
- [9a. FACILITY NAME (If not institution, give	1 /	78	1110.	9b. CITY, TOWN OR LOCATION OF DEATH						sylvania	
r							DEATH					
CTOR	Carroll County	Jeneral nos	pitai		wes	tminster		Carroll				
Į.	10e. STATE 10b. COUN	TY		10c. CITY, TOWN OR LOCATION						10	d. INSIDE CITY	
5	Maryland Car	roll		1	Vestmi	nster		1.5	LIMITS?			
	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITIZI	EN OF WHA	T COUNTRY?	
	540 T4 Lacosta (Circle				211	58		U	USA		
LONEHAL	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 Y			13. WAS	DECENDENT OF HIS	PANIC ORIGI	N? (Specify Yea	or No- 1	4. RACE -	American Indian,	
- 1	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OF					ocify:	riican, etc.)	- 1	Specify:	White	
COMPLETED BY	15. DECEDENT'S ED	ICATION	40: 04		1						Willie	
	(Specify only highest grad	le completed)	/G	Bive kind of v Do NOT us	WORK done during the retired	PATION g most of working	16	b. KIND OF BUS	SINESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+) n/a	1		ntenda	nt		Boat	ina			
	17. FATHER'S NAME (First, Middle, Last)			ipei ii	recince		NAME /El-	Middle, Maiden				
	Stanley Zuram	ski				-1-1-1-11		essar				
TO BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S)	reet and Number or Ru						
2	Marjorie P. Zura	mski				costa Cir					21158	
ŀ	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rec		20b. PLACE		OF DISPOSITIO		DA		CATION — CI			
Ì	4 Donation 5 Other (Specify)	noval from State	Lake	view	Memor	ial Park	10/14	/95 S	vkesi	ville	MD	
1	21. SIGNATURE OF FUNERAL SERVICE DEENSED // C. Lakeview Memorial Park 10/14/95 Sykesville, A											
	Bryan W. Clary Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093											
	23. PART I. Enter the diseases, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate											
	andck, or heart fellure	List only one cause or	each line	ð.		mode of dyning, a	don de car	diec or reapr	atory arre	и,	interval Betwee	
	iMMEDIATE CAUSE (Final disease or condition	1/ E/113	21	R111	00	1000	LUID	OPN	10		Onset and Dea	
1	resulting in daeth)	e. DUE TO (OR A	S A CONSE	OUENCE OF	Pi: _	1ACT	170	1110	173	•		
						DRY	1)19	DA	15		i	
Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
	cause. Enter UNDERLYING	c										
	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
	resulting in death) LAST	d										
	PART ii. Other aignificant condition	na contributing to deat	h but not i	resulting i	in the undar	lying cause given	in Part i.	24s. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDING	
	DIFFISE	ARGOT	.CE	41	141	nound	7.4	PERFOR	MED?	AVE	AILABLE PRIOR TO MPLETION OF CAUSE	
				1 YES 2 1 NO 0							DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEA	TH YE	S \square NO	☐ UNCERTA	IN M				YES 2 NO	
	25. WAS CASE REFERRED TO MEDICAL			_	H (Check only							
PHYSIC	1 YES 2 NO	H@SPITAL:	utpatient 3	DOA	OTHER:	Home 5 Residence	e 8 🗆 Oth	er (Specify)				
	27, MANNER OF DEATH	28s. DATE OF INJUR (Month, Day, Yes		28b. TIM		INJURY AT WORK?	_	SCRIBE HOW II	JURY OCCU	RED		
	1 Natural 5 Pending Investigation	(Moral, Say, 10g	.,	Ind		YES 2 NO						
	3 Suicide 6 Could not be	28s. PLACE OF INJU- building, atc. (S	IRY — At he	ome, farm, s	treet, factory,	office	281. LOC	CATION (Street a or Town, State)	nd Number or	Rural Route	Number,	
	4 Homicide determined						J. Oily	or lowit, Statey				
4 II	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kn	owledge, de	eth occurre	d at the time,	data and place, and d	lue to the ca	use(a) and man	ner as stated			
200		ER: On the beals of examina									d manner as stated.	
┇╟	296. SIGNATURE AND TITLE OF CERTIFIE	R O	1			29c. LICENSE N	IUMBER		294. DATE 1	HOMED (SA)	orth. Diss. Wears	
	\$19.1808 A	XUID	N	1.1		DZ	DS.	2_	> /	01,	11/9	
	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF	DEATH (ITE	M 27) (Type,	Print)					1/	2/1/2	
	MAKEEZ A	34(27)	m	0 2	20 (magka	2019	Dr	A.	dina	E Millo	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE	9					-41-1	11/1/2	11.21.43	
- 1	OCT 1 7 1995	falia dander	randal	6						/		

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



MIVISION OF VITAL RECORDS, P.O. BOX 68769 BALTIMORE, MARYLAND 21215-0020	O THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION	THE HOSPITAL OR ATTENDING PHYS	THE FUNERAL DIRECTOR: After this of filed within 72 hours after death with	MPORTANT: If Item 28 is marked

	FOR 1 - STATE REGISTRAR	STATE OF N					EALTH DEAT		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					DEA		2. DATE OF DEATH			3. TIME OF DEATH	
	ELLA VIRO	SINIA	ZUKAS	S					OCTOBER 1	AY 6 19	YEAR	5:00 A. M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	0, 13		PLACE (State or Foreign	
	216-10-7040	1 🗆 M 2 💢 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 08-21-190	7	Countr	YLAND	
	9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY	TOWN O	R LOCATIO	ON OF DE			TY OF D		
Œ	2807 MAISEL STRE						IMOR			N/		LAIII	
E	RESIDENCE OF DECEDENT								-				
DIRECTOR	10e. STATE 10b. COUN			10c. CIT	Y, TOWN C	OR LOCAT	ION					10d. INSIDE CITY LIMITS?	
	MARYLAND	N/A		BA	LTIM	10RE						1 TYES X NO	
AL	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CITI		WHAT COUNTRY?	
FUNER	2807 MAISEL STRE	EET					2	21230)		U.	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED					IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	s or No-		E — American Indian, k, White, etc.	
ВУ	1 Never Merried 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE Y	WAR OR DATES				2 X NO				Spec		
ED B			Trans									MUTIE	
	15. DECEDENT'S ED (Specify only highest gra-	de completed)	(G	CEDENT'S ive kind of Do NOT u	work done	during mo	on st of workin	g	16b. KIND OF BU	ISINESS/IND	USTRY		
12	Elementary/Secondary (0-12)	College (1-4 or 5	+)			7			7 50	O SPA	CE		
COMPLET	8 17. FATHER'S NAME (First, Middle, Last)	N/A		GUARI)E,III	2.0	10 MOTI	HED'C NA	ME (First, Middle, Malde		CL		
		LATE	IE				ELI		VIRGINI			WILSON	
出	THOMAS 190. INFORMANT'S NAME (Type/Print)	LAII		h MAILING	ADDRESS	S (Street e			Route Number, City or To		Codel	WILDON	
2	JEAN LORRAINE SE	WIDCK	1						BALTIMORE,			21230	
	20e. METHOD OF DISPOSITION		20b. PLACE	-				J., 1	DATE 1 20c. L	OCATION -	City or To	own State	
	1 N Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery, cre	matory or o	ther place)			DADK				E, MARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	- ODDIA	IIII					CILITY SINGLE				
	M. 1.1	116	11.	2								E,MD.21061	
	/ CICHOUL	U. 90	Hinn										
	23. PART I. Enter the diseases, o shock, or heart failure	r complications the b. List only one can	rypassed the de use on sech ilns	isth. Do i I.	not enter	the mo	de of dy	ing, suc	h ss cardlec or ras	olratory an	rest,	Approximets interval Between	
	IMMEDIATE CAUSE (Final)										Onset and Death		
1 1	diseese or condition resulting in death)	a. Gere	prova	ena	VD	400	ade					gyrs.	
		1 DUE TO	(OR AS A CONSE	OUENCE O	F):	- 1-	0					/	
O	Sequentially list conditions,	b. 17900	WYELLSE	OHENCE O	E ST	20470	u,						
ATI	if sny, lesding to immediats cause. Enter UNDERLYING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(or no n contact	002.1102.0	. ,.							į į	
밀	CAUSE (Disesse or injury that initiated events	C. DUE TO	(OR AS A CONSE	OUENCE O	F):								
CERTIFICATION	resulting in dasth) LAST	4											
1 1	DAPT II Oak as also Massa as a dist												
SAL	PART II. Other significant conditi	ons contributing to	death but not i	resulting	in the u	nderlyin	g ceuse	given in	Part I. 24a. WAS A	RMED?	246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
									1 TYES	2 1010		DF DEATH?	
MEDI							- 10000					1 _ YES 2 _ NO	
Z,	DID TOBACCO USE CON	TRIBUTE TO CA					JUNC	ERTAII	иЦ				
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEA	OTHE								
ΥS	1 YES 2 NO		ER/Outpatient 3				_	esidence	6 Other (Specify)				
	1 Notural 5 Pending	26e. DATE Of (Month, I	Day, Year)	26b. TIN	JURY M	WC	URY AT	7	28d. DESCRIBE HOW	INJURY OC	CURED		
BY	2 Accident Investigation		OF INJURY — At he	ma taum	oter-t to-		YES 2	NO	28t. LOCATION (Street		- 0 - 1	0	
8	3 Suicide 8 Could not b		. etc. (Specify)	, terri,	street, tec	tory, orne			City or Town, State		or Hurai	House Number,	
틸	29e, CERTIFIER				-								
MP	(Check only								to the ceuse(s) end m				
COMPL	2 MEDICAL EXAMI	NEH: On the Besis of	exemination end/or	Investigati	on, In my	opinion, d	lesth occu	red at the	time, date end place, i	ind due to ti	ne cause(e) end menner es stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIF	IER //					29c. LIC	ENSE NUI	MBER	29d. DAT	E SIGNED	(Month, Day, Year)	
2	July felle	1110	/				1	1/98	758	- u	1	6, 1995	
	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAL	JSE OF DEATH (ITE	M 27) (Type	o, Print)	7/.	A	~	0/ // 1/	10			
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

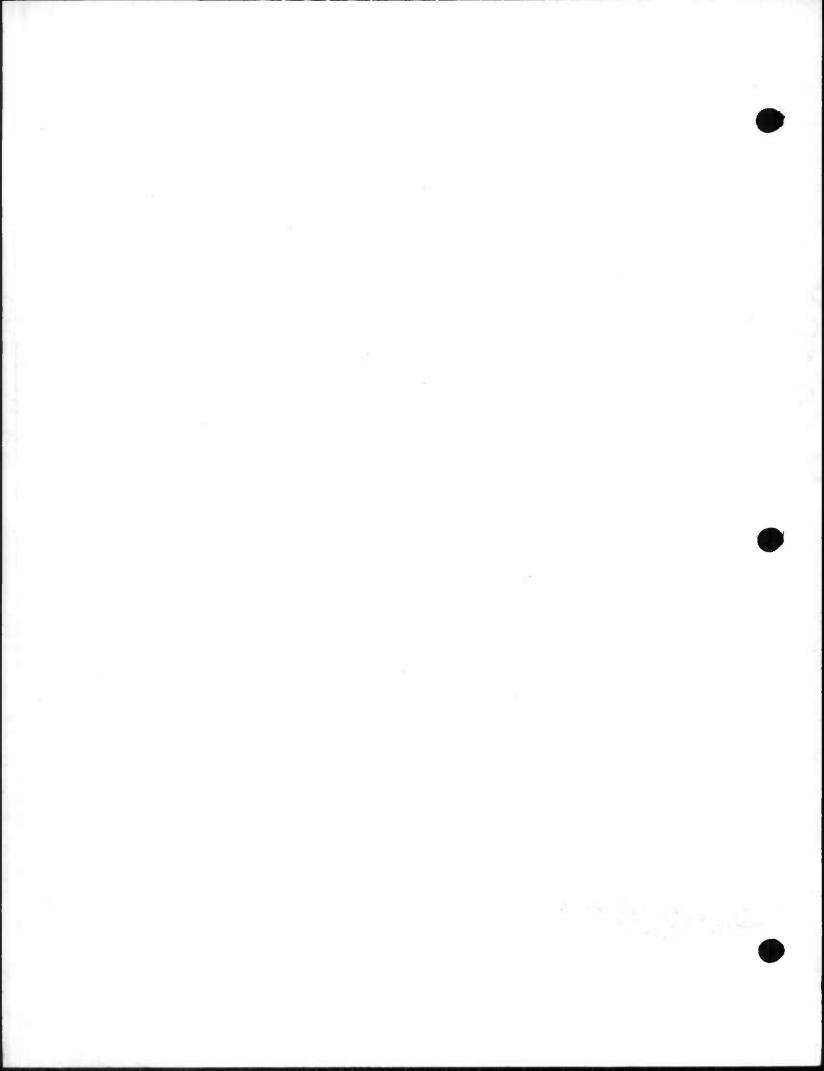
STATE	0F	MARYLAND	1	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	E	RTIFICATE	O	F DEAT	TH		REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTA	HYGIENE			
	1. DECEDENT'S NAME (First, Middle, Last) Edna ZaliS					2. DATE MONTI	OF DEATH	, 199	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 4. 99289571	1 🗆 M 2 💢 F	9 YRS. MON		IF UNDER 24 HRS. HOURS MIN.	Ju	OF BIRTH h, Day, Your)	26	MISS	SOURI
TOR	96. FACILITY NAME (If not institution, give st SINAI HOSPITAL RESIDENCE OF DECEDENT	reet and number)	96,	BALTI	MORE	EATH		9c. COUNT	Y OF DE	N/A
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND N/		10c. CITY, TO	WN OR LOCAT BALTI						10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 6317 PARK HEIGHTS	AVE, APT. 602		101	ZIP CODE 21215	5		10g. CITIZI	EN OF WHAT COUNTRY?	
ВХ	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 V NO		ENDENT OF HISPAP city Cuben, Mexice 2 NO Specifi	n, Puerto l		or No 1	14. RACE Black, Specify	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU(Specify only highest grade Elementary/Secondary (0-12)		8a. DECEDENT'S USU (Give kind of work of the Do NOT use ret	done during modired.)			COOD DI			ON
E COM	17. FATHER'S NAME (First, Middle, Last) SOLOMON	CHER		VL	18. MOTHER'S NA LEBA				COH	
TO B	19e. INFORMANT'S NAME (Type/Print) MR. LEON	ZALIS	19b. MAILING ADD 6317 PA	RESS (Street a	GHTS AVE	Route Num	ber, City or Town, APT. 60	Stere, Zip C 2 BAL	Code) TIM	ORE,MD 21215
CERTIFICATION	23. PART I. Enter the disease of shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	6010	D ADDRESS OF FA EVINSON REISTERS de of dying, auc Distre	STOWN	N ROAD	BALTI	et,	E, MD 21215 Approximate Interval Batween Onset and Death Year Week		
MEDICAL	PART II. Other algnificant condition				g cause given in		24a, WAS AN A PERFORM	MED?	24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	PLACE OF DEATH (C	Check only one)						
BY PHYS	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1) Inpatient 2 ER/Outpat 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	M 1 1	RK? /ES 2 NO	28d, DE	er (Specify) SCRIBE HOW IN			
60	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, term, street, factory, office City or Town, State)									
COMPLET	need ormy	ER: On the best of my knowled								and menner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE ONNE M. Patt 30. NAME AND ADDRESS OF PERSON WITH	29c. LICENSE NU AS 2401	2402321AP988 Detaber 12, 1995							
	Anne M. Petern 31. DATE FILED (Month, Day, Year)	el 2401	W. Belv	reder	e Ba	ltin	norey	MD	2	1215
	OCT 1 7 1995	32. REGISTRAR'S SIGNAT	rdell							

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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last) Khaya Z	Zukin				2. DATE OF DEATH MONTH OCTOBER	DAY	VEAR	TIME OF DEATH 2:49 Pm
Þ		4. SOCIAL SECURITY NUMBER 217-25-9255	5. SEX 6. AGE	(In yrs. lest birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUNE 12,			CE (State or Foreign
2, 3 should	стоя	9a. FACILITY NAME (If not institution, give st JOHNS HOPKINS BAY RESIDENCE OF DECEDENT		L CENTER	96. CITY, TOWN	OR LOCATION OF DI	ATH	9c. COUNT	Y OF DEATH	
Pages 1.	DIREC	10a. STATE 10b. COUNTY	I/A	10c, CIT	TY, TOWN OR LOCA				LINSIDE CITY	
permit.		10e. STREET AND NUMBER				IMORE 1. ZIP CODE		10g. CITIZE		YES 2 NO
020 physician. burial-transit	FUNERAL	3615 FORDS LANE, A	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DEC	CENDENT OF HISPAN	21215	US /es or No — 14	American Indian,	
215-0020 attending physic	BY	1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 _ YES IF YES, GIVE WAR OR D			ecify, Cuban, Mexica 2 Z-NO Specify	n, Puerto Rican, etc.)		Black, Wh Specify:	WHITE
retained by the hospital or 5 should be detached for unofilfied at once.	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of life. Do NOT us	WSUAL OCCUPATION Work done during mose retired.)	ON ost of working	16b, KIND OF B	USINESS/INDUS	ITRY	
	COMPLET	17. FATHER'S NAME (First, Middle, Last)	5+	PF	EDIATRIC		MEDICI ME (First, Middle, Maide			
	BE	YOSEF 19a. INFORMANT'S NAME (Type/Print)	MIROC		ADDRESS (Street)	and Number or Buret I	MOLLY Route Number, City or R		GORES	HNIK
	5	MR. SEMYON 208. METHOD OF DISPOSITION	ZUKIN	3615	FORDS L	ANE, APT.	. 412 BALTIMORE, MD 21215			
MORE age 6 may director, pay		1- Burlet 2 Cremation 3 Remo	oval from State Cen	D. PLACE AND DATE	K ^{her} SINAI	10	- 13 - 1995-			
SALII death. P e funeral al. examin		21. SIGNATURE OF FUNERAL SERVICE LICE	. Cutth	7	6010	REISTERS		BALTI		MD 21215
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		23. PART i. Enter the diseases, or c shock, or heert failure. I iMMEDIATE CAUSE (Finel disease or condition resulting in death)	A SCVD	d the death. Do nech line.		de of dying, auc	h aa cardiac or res	piratory arrea	t,	Approximata interval Between Onset and Death
th certificate be executed ending physician and con I Hygiene prior to buriat, or other traumatic en	RTIFICATION	Sequentially list conditions, if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events rasulting in death) LAST	DUE TO (OR AS A		F):					Years
the day the or Injury	AL CE	PART II. Other significent conditions	contributing to death b	out not resulting	In the underlying	g ceuse given in	Part I. 24a. WAS A	IN AUTOPSY DRMED?		RE AUTOPSY FINDINGS
equires the en signed of Health	MEDICAL	Echinococcus					1 YES	2 X NO	OF C	PLETION OF CAUSE DEATH? YES 2 1 NO
The law the has the date Dept	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		UNCERTAIN				
SICIAN: The certificate in the State d, or item	PHYSI	1 TYES 2 NO 27. MANNER OF DEATH	1 N Inpetient 2 ER/Outp	28b. TIM	4 Nursing Hom		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCU	AED	
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 128 is marked, or it	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1 🗆 '	RK? YES 2 NO				
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	olfy)			28f. LOCATION (Stree City or Town, Star	0)		Number,
4 4 2 F	COMPLET	29a. CERTIFIER (Check only one) 29a CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner.								
TO THE HOSPIT TO THE FUNERA DE filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 20dd J. Coy, N	10			96015		29d. DATE S		in, Day, Year) 11, 1995
?		30. NAME AND ADDRESS OF PERSON WHO		Hopkins Bayview Medical Center, Boutimore, MD 212						
		31. DATE FILED (Month, Dey, Year) OCT 1 7 1995	32 REGISTRAR'S CON	Z.W.			·			



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Derf of Health and Mental Haviago price having or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.
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he law requires that th	e has been signed by the Death and	m 23 shows any in
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THE HOSPITAL OR ATTE	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi he filed within 72 hours after death with the State Dent, of Health and Mental Honlane notor in burial cremation or remove	PORTANT: If Item 28
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	1 - FOR STATE REGISTRAR	STATE OF MARYL			OF HEALTH AND OF DEATH	MENT	AL HYGIEN			0-00		
	1. DECEDENT'S NAME (First, Middle, Lest) DORIS	M.	ZA	LNEI	R	MON		AY 07	YEAR	TIME OF DEATH		
	041160178	1 - M 2 1 F 75	(In yrs. last birthda	/) F UNDER 1 1		7. DATI	E OF BIRTH with, Day, Year)			ACE (State or Foreign		
TOR	90. FACILITY NAME (If not institution, give stre The Good Samarita RESIDENCE OF DECEMENT				own or Location of C	DEATH		9c. COU	ore City			
DIRECTOR	10a. STATE 10b. COUNTY	rford	10c. (Be	LOCATION lair				1 2	Dd. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	300 Sunflower Dr.				101. ZIP CODE 2101	4		10g. CIT	USA	AT COUNTRY?		
B₹	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 X NO	If y	S DECENDENT OF HISPA es, specify Cuben, Mexic YES 2 NO Spec	en, Puerto	IN? (Specify Yes Rican, etc.)	or No—	Black, \ Specify:	American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) 12 yrs.	TION propleted) College (1-4 or 5+) N/A	(Give kind	's USUAL OCCE of work done duri use retired.)	JPATION ng most of working	16	Branch		USTRY	WIITCE		
TO BE CON	17. FATHER'S NAME (First, Middle, Last) Joseph John Mack					ces	Middle, Maiden Zalonis	Surname)				
10	199. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert J. Zalner 1308 Belle Meade Rd. Fallston, Md. 21047											
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of Competent, Cremetory of other place) 10-16-95 New Britain, Conn.											
CYCLE	· Heather Las	eschol		Las	Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236							
	23. PART I. Enter the diseases or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final											
eveni,	disease or condition a. CONGESTIVE HEART FAILURE 1 Day Due to (or as a consequence of):											
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Industry) INSULIN DEPENDENT DIABETES MELLITUS 754RS											
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS /			ENT DI	100	165	MEL	-/ 143	73985		
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AU PERFORME 1 YES 2 (V							IMED?	Al Co	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE DEATH?			
								TES 2 (L/NO				
PHYSICIAN:	EXAMINER?	HOSPITAL:	26. PLACE OF DE	OTHER:	Home 5 Residence	6 🗆 Oth	er (Specify)					
ВУ РН												
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)											
COMPLETED	29a. CERTIFIER (Check only one) 1 **CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner ee stated. 2 **MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.											
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) 29d. DATE SIGNED (Month, Day, Your) 29d. DATE SIGNED (Month, Day, Your) 29d. DATE SIGNED (Month, Day, Your)												

AME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

JOSEPH BOATENG

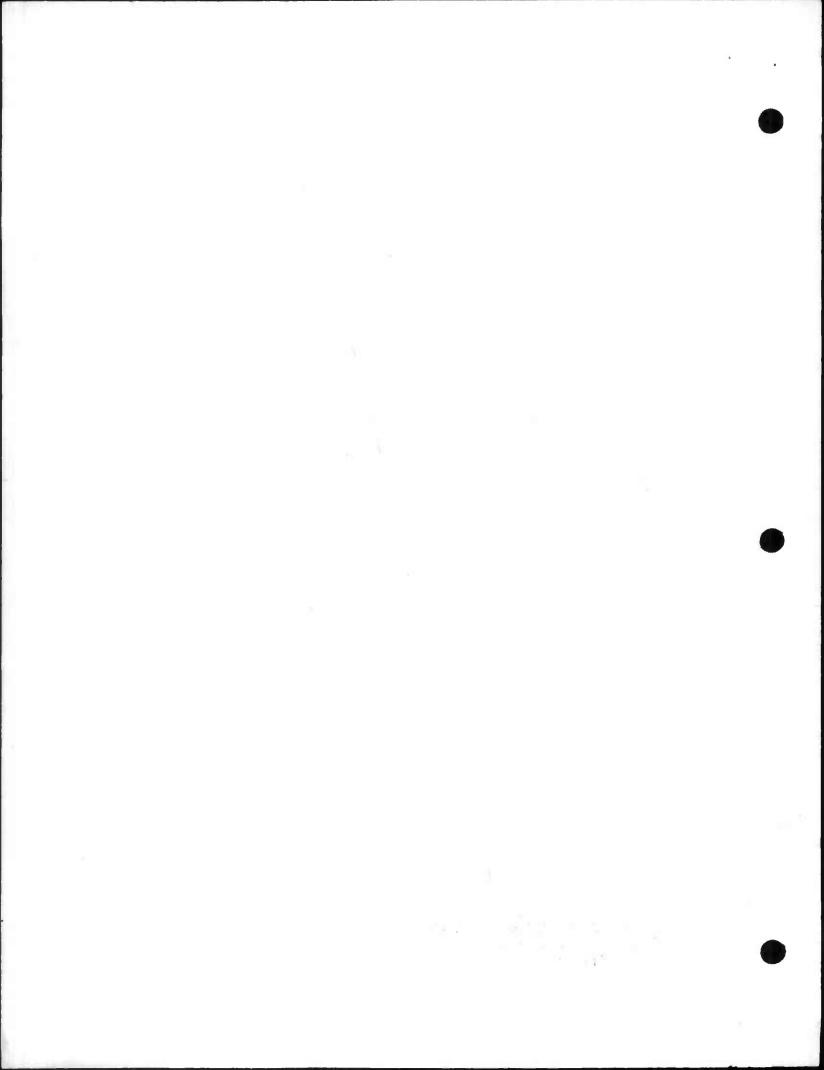
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3 REGISTRATS GIVEN

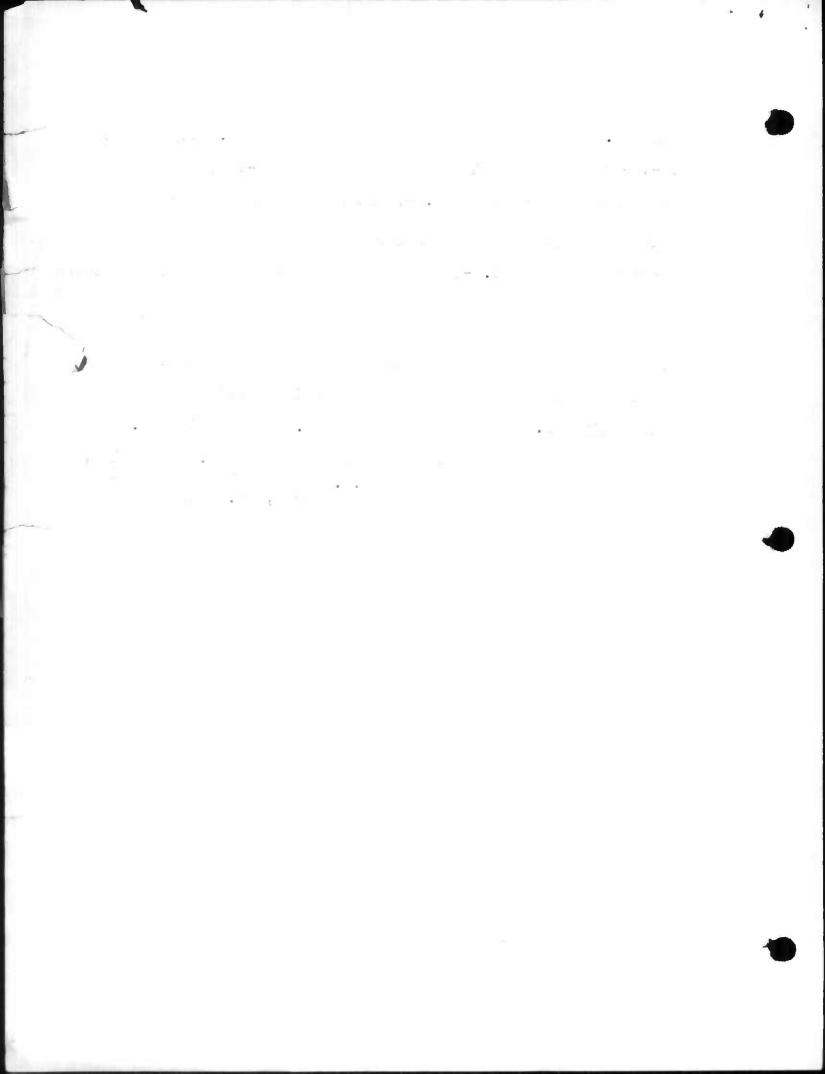
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BALLIMORE, MANTLAND ZIZOS-3140	vurs after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	event, the medical examiner must be notified at once.
DIVISION OF VIIAL RECORDS, P.O. BOX 13146, BALLIMONE, MARTLAND 21203-5146	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Yours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20 Stanley White Sr. 34261 Worth Rd.Pocomoke City, Md.21851 20 Servation or pispositrion 1 Department of Composition (Nature of complex), commissory or Charles (City or Town, Stele City Md. 22 Servation of City or Town, Stele City, Md. 23 Servation or City or Town, Stele City, Md. 24 Department of City or Town, Stele City, Md. 25 PART I. Enter the diseases, or complications that perfect the death, Dub of enter the mode of dying, such as cardlec or respiratory streat, Indicate City or Town, Stel	띪		10h MAH NIC ADDRE		-0	Otata Tin Cardal						
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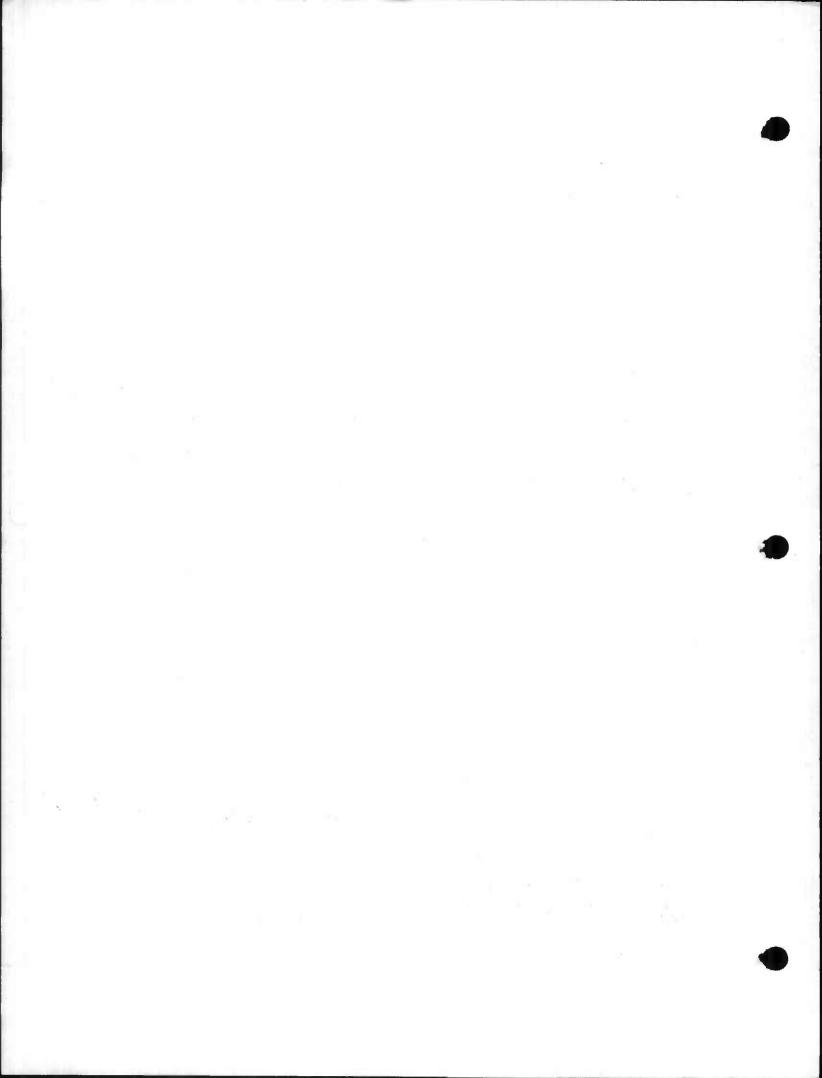
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	REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Leet) 2. DATE OF DEATH 3. TIME OF DEATH																
	HOWARD J. ANTHONY III					JULY 16, 1995 YEAR 11:35 A											
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last		IF UNDER 1 YE		ER 24 HRS.	7. DATE O			8. BIRTHPL/ Country)	NCE (State or Foreign					
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œ	9e. FACILITY NAME (If not institution, give				96. CITY, TO	WN OR LOCA	TION OF DE	HTA		9c. COUN	TATE	н					
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DIRECTOR	10a. STATE 10b. COUNT	гү		10c. CIT	Y, TOWN OR L	OCATION						d. INSIDE CITY					
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FUNERAL						10f. ZIP CC				10g. CITIZ		COUNTRY?					
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Com thing	7 Farmer Farming 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Malden Surreme)																
D	Howard J	thony,	Jr.						-	,							
2	19e. INFORMANT'S NAME (Type/Print)	19b	MAILING	AALING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
	Jennifer Wright 3555 Bradley Road, Federalsburg, Maryland 21632																
	20e. METHOD OF DISPOSITION 1X Burlel 2 Cremetton 3 Removal from time 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetery, cremetery, cremetery or other place)																
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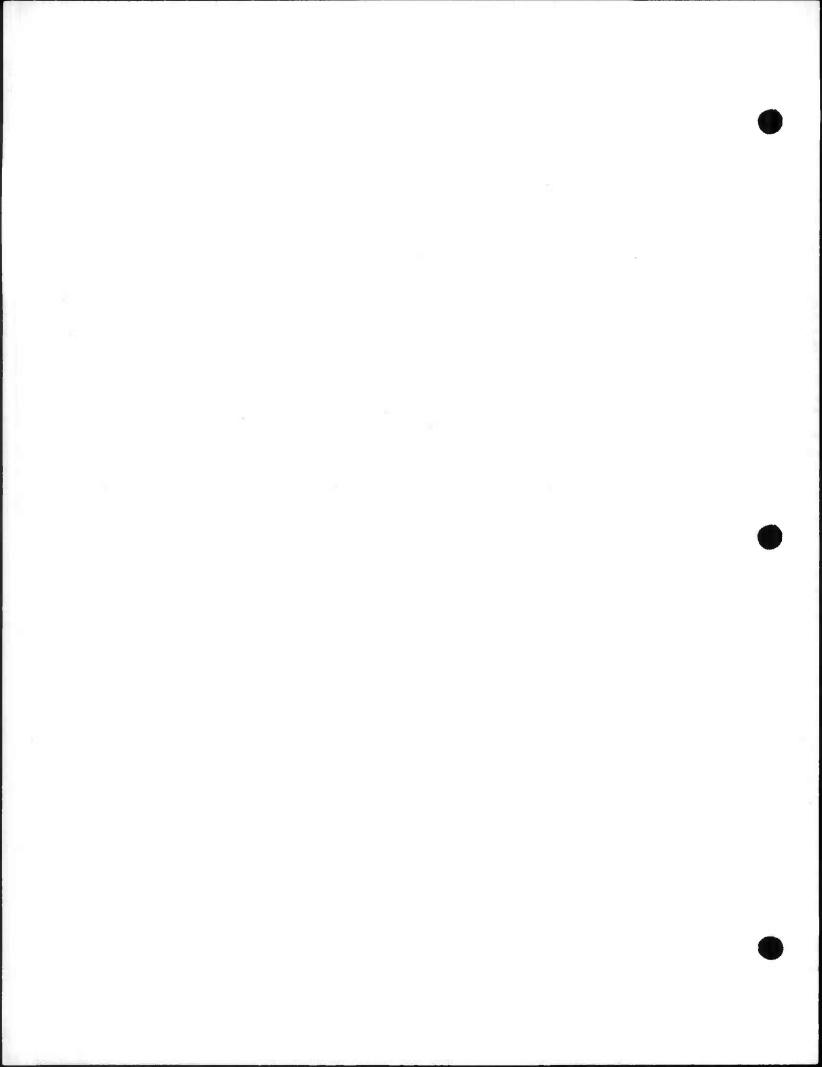
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2,	DIRECTOR	UNIVERSIT	HOSI	PΙ
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mit.	1	Maryland 100, STREET AND NUMBER	Caro	1.
	FUNERAL		D 1	
020 physician. burial-transit	=	26250 Hobbs	Road	12
20 hysic urial			Married	12
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™ 5 8		15. DEC	EDENT'S EDUC	CATI
212	ed at once. BE COMPLETED	(Specify onl	y highest grade	com
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AND the hospit detached	OOM COM	17. FATHER'S NAME (First, M	liddle, Last)	
7 A B B B B B B B B B B B B B B B B B B	# O	710	xander	
IAR I	B 6	19a, INFORMANT'S NAME (
MA retail	TO BE		nner	
ay be	2	20s. METHOD OF DISPOSIT		_
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N 2 4	E .	4 Doration 5 OOther		·
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m # # #	lica lica	23. PART I, Enter the d		
d in	Ě		eart failure.	List
y fill	å.	iMMEDIATE CAUSE (Find disease or condition	100	
Mr. Pletel	event,	resulting in deeth)		e
P.O. BOX 6876: h certificate be executed will 2.24 anding physician and completely fill Hygiene prior to burial, cremation,				
Section and and bull	te O	Sequentially list condit		b
O be per licitary	TAT	If any, leading to imme cause. Enter UNDERLY		
fical fical physics	other traumatic	CAUSE (Disease or Injuthat Initiated events	iry	C
Certification Hygie	or of	resulting in deeth) LAS	T	
DS, P he death the atter Mental	S S			o
OF VITAL RECORDS, P.O. BOX 6876. PHYSICIAN: The law requires that the death certificate be executed with this certificate has been signed by the attending physician and completely fill with the State Dept. of Health and Mental Hygiene prior to burial, cremation	ed, or item 23 shows any injury, or other traumatic PHYSICIAN: MEDICAL CERTIFICATION	PART II. Other aignifica	nt condition	5 C
That the ed by the and	amy DIC			
RECO requires the een signed of Health	shows : MEC			
R v req	%	DID TOBACCO U	JSE CONTI	RIB
AL has bep	1 23 AN	25. WAS CASE REFERRED 1	O MEDICAL	
N: The State	item SICI/	EXAMINER?		Х
OF VITAL PHYSICIAN: The law this certificate has b with the State Dept.	rked, or PHYS	27. MANNER OF DEATH		Δ
PHY With	-36		Pending	
NG Affer Affer Meath	mar BY	2 Accident	Investigation	
SIC SIC OR: /	8 E	3/ \$uicide 6 4 Homicide	Could not be determined	
DIVISION OR ATTENDING DIRECTOR: After hours after death	ET ET	200 CESTIFIED		
DIVISION TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death	IMPORTANT: If Item 28 is mar TO BE COMPLETED BY	Check only	TIFYING PHYS!	_
NER!	N O	N MED	ICAL EXAMINE	R; C
공교	E C	296. SIGNATURE AND TITLE	OF CERTIFIE	1
E E E E	MPC	1000	er 1	-
	1 2	34 NAME AND ADDRESS O	F PERSON WH	0 C
		TLALON	JIA	4
		31. DATE FILED (Month, Day		,
		TITLE A TO		

1 - STATE REGISTRAR		STATE OF MARY	AND / DEPARTM			MENTA	L HYGIEN				
1. DECEDENT'S NAME (First	, Middle, Last)		OLITITIO	AIL OI	DEATH	2. DATE	OF DEATH		2.1	3. TIME OF DEA	TH
SCOTT	λТ	EXANDER		AUST	TN CE	MONT	H D		995		
4. SOCIAL SECURITY NUMBER			(In yrs. last birthday)	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		. BIRTHP	LACE (State or I	
002-56-48)))	M 2 F	24 YRS.	NTHS DAYS	HOURS MIN,	June	12, 19	71 N		achuset	ts
UNIVERSITY	HOSPI			BALTIN		EATH			TIM		
10a. STATE	10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION	_			T	10d. INSIDE CIT	Υ
Maryland	Carol	ine	De	nton						LIMITS?	NO
100. STREET AND NUMBER				101	ZIP CODE			10g. CITIZE	EN OF WI	HAT COUNTRY?	
26250 Hobbs					21629				S.A		
11. MARITAL STATUS 1X Never Married 2 3 Wildowed 4 Divo	Married	P. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	It yes, sp	ENDENT OF HISPAI Icity Cuben, Mexica 2 NO Specif	en, Puerto			Black, Specify	- American Inc White, etc. :: asian	llen,
15. DEC	EDENT'S EDUCAT	ION	16a. OECEDENT'S US			161	b. KIND OF BU			astan	
(Specify online Elementary/Secondary (I	y highest grade con	npleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo stired.)	st of working						
12 HS grad.			Binder	y Worke	er		Pr	intino	ī		
17. FATHER'S NAME (First, M	liddle, Last)				18. MOTHER'S NA	AME (First,			-		
Ale	xander	Richard	Austin		Su	san 1	Ellen	Purir	ato	n	
19a. INFORMANT'S NAME (- ALASKANAS		DRESS (Street a	nd Number or Rural				-		
Susan E. Co	nner		26250	Hobbs I	Road, Dei	nton	, Mary	land 2	2162	9	
20s. METHOD OF DISPOSIT			b. PLACE AND DATE OF D		me of	DAT	TE 20c. LC	CATION - C	ity or Tow	rn, State	
4 🗆 Domition 5 🗆 Other	(Specify)		Eastern Sh	ore Cre	ematoriu	m 10,	/6 Ge	orgeto	own,	Delawa	re
21. SIGNATURE OF PUNERA	L SERVICE LICEN	# / / m			D ADDRESS OF FA		- D				
1 Deer	roppi	5,000	one		re Funera Orawer B				bac	21620	
23. PART I. Enter the d	ineases, er con	plications that cause	ed the death. Do not							Approxi	nete
shock, or h	eart failure. Lis	t Dnly Dne cause Dn	each line.							Interval I	
iMMEDIATE CAUSE (Findisease or condition_	381	Mal	15 06	Las	11.00					0	
resulting in deeth)	e	OUE TO (OR AS	A CONSEQUENCE OF):	1	urces	•				+	
				V						1	
Sequentially list condit If any, leading to imme	iona,	DUE TO (DR AS	A CONSEQUENCE OF):								
cause. Enter UNDERLY CAUSE (Disesse or Inju											
that initiated events resulting in deeth) LAS		DUE TO (OR AS	A CONSEQUENCE OF):								
resulting in deeth) LAS	d									-	
PART II. Other aignifica	int conditions o	ontributing to death	but not resulting in	the underlyin	cause given in	Part I.	24s. WAS AF		24b.	WERE AUTOPSY	FINDINGS
							PERFO	11		AVAILABLE PRIO COMPLETION OF	
							1 TYES	NO		OF DEATH?	
DID TOBACCO U	ISE CONTRIE	LITE TO CAUSE (OF DEATH YES		UNCERTAL	N D				1 YES 2	NO
25. WAS CASE REFERRED 1		JOIL TO CAUSE V	26. PLACE OF DEATH	- Y	CONCERNA						
EXAMINER?	H	OSPITAL:	2 000	THER:							
27. MANNER OF DEATH	Z	28e. DATE OF INJURY			e 5 Residence			INJURY OCCI	IRED		
1 Natural 5	Pending	(Month, Day, Year)	INJUR	W WC	RK?		VER	IN AU	TO/	AUTO	
2 Accident	Investigation	9/29/19 28e, PLACE OF INJUR	95 10740 IY — At home, term, stre		-8.5		CATION (Street	and Number of	v Bucel B	outs Number	
4 Homicide	Could not be determined	building, etc. (Sp	ecify)							TSBUR E COU	
29s. CERTIFIER		N: To the best of my kno		STREET						E COU	NII,
Consult Only		N: To the best of my kno On the basis of examinati								and merces	etete.d
1			S. Sidroi investigation,	my opinion, c	11-11-11		e and piace, 8				
296. SIGNATURE AND TITLE	OF CERTIFIER	6 UM	1)		29c. LICENSE NU					(Month, Day, Yee	
1400	r	UNK IN	4		0.C.	М.Е.	. 00	TOBE	R 1	, 199)
TAR LUN	J LOC	- 400			et, Ba	ltin	nore,	Marv	lan	d 212	01
31. DATE FILED (Month, Day	Year)	32 REGISTRAN'S SIG	NATURE							==	-
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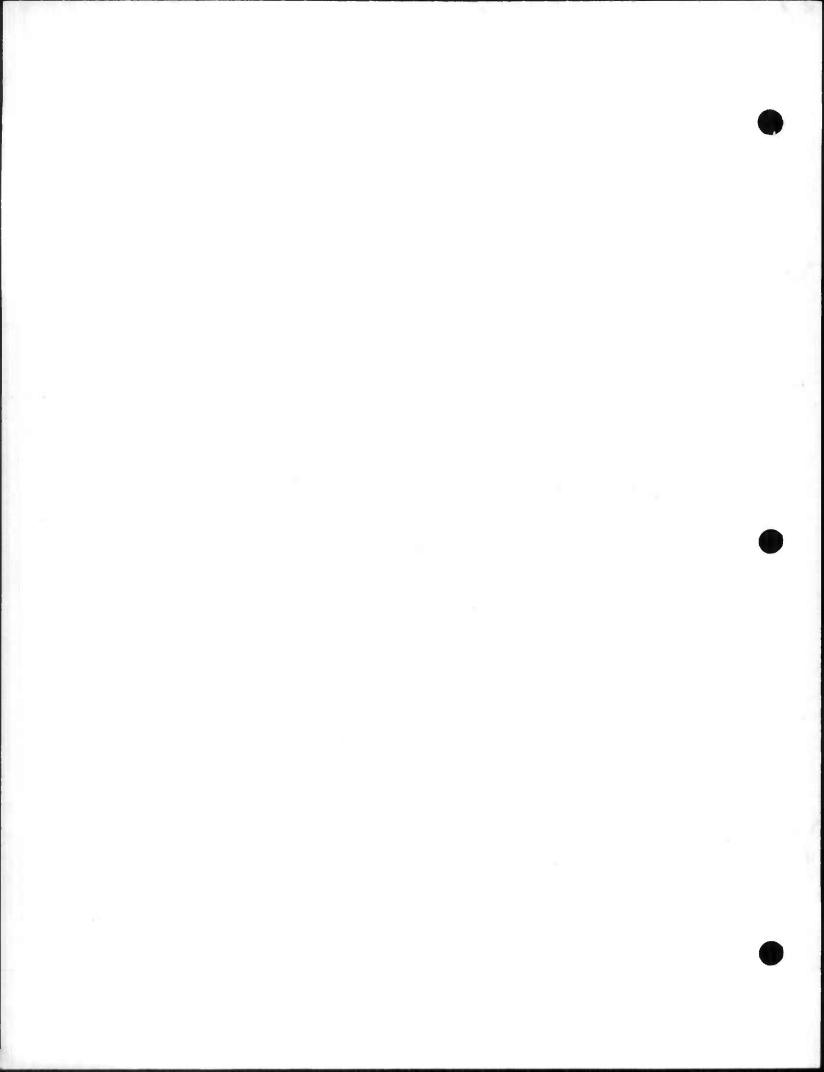
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL HYGIEI				
		1. DECEDENT'S NAME (First, Middle, Last)	Adkins s	Sr.			2. DATE OF DEATH MONTH	DAY YEA			
P		4. SOCIAL SECURITY NUMBER 215-44-8167	18 M 2 □ F 83	(in yrs. lest birthday) YRS.	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 24	,1912	RTHPLACE (State or Foreign Surity) Kentuckey		
2, 3 should	DIRECTOR	9a. FACILITY NAME (H not institution, give s Charlestown Me		er		or Location of C		9c. COUNTY C	timore		
) sec 1,	E C	10a. STATE 10b. COUNT	Y	10c. CI	TY, TOWN OR LOCA	ATION			10d. INSIDE CITY		
emit. Pa		Maryland Bald	timore	С	atonsv	ille		10a CITIZEN	LIMITS? 1 YES 2 NO DE WHAT COUNTRY?		
nsit p	ER/	719 Maiden C	hoice Lane	- HR11		21228		U.S			
physician. s burial-transit permit. Pages 1, 2,	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Diverced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 XNO	If yes, s	CENDENT OF HISPA	NIC ORIGIN? (Specify Yo an, Puerto Rican, etc.)	na or No— 14, R	ACE — American Indian, Black, White, atc.		
r attending	ED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPAT work done during m	ION	16b. KIND OF BU	USINESS/INDUSTR			
. 0 -	E	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do NOT u	se retired.)	lost or working	Fede	eral Po	ver		
the hospital detached to	COMPLET	12 17. FATNER'S NAME (First, Middle, Last)	4	Engir	neer	18. MOTHER'S N	AME (First, Middle, Melde	n Sumame)			
28 %	BE (Hilan Herm	an Adkins					ates			
be retained to ge 5 should e notified	10	19a. INFORMANT'S NAME (Type/Print) Edith Johnson	Adkins				Poute Number, City or To				
6 may ctor. pa		20e. METHOD OF DISPOSITION 1		PLACE AND DATE			OATE 200. LO	ocation – city o	a, Maryland		
death. P funeral	8	21. SIGNATURE OF FUNETILL SERVICE LICE OVERT Z.			22. NAME A	IL. MO	esworth,	P.A., F	uneral Hom		
cal after		23. PART I. Enter the diseases, or o	complications that caused	the deeth, Do	1 Z 0 4 U	ode of dying, suc	h as cardiac or reat	IndSCUS	, Maryland		
fille ion,		shock, or heert feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	At his sclar	ach line.				,,	interval Between Onset and Death		
B 0 8	z		DUE TO (OR AS A	CONSEQUENCE O	F):						
cian a lor to	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE O	F):						
ending Hygie	CERTIF	thet initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in dasth) LAST									
Me de	_ 1	PART it. Other algnificent condition	a contributing to death b	ut not reaulting	in the underlyin	ng ceuse given in	Part I. 24s, WAS AI	N ALITOPSY I	24b. WERE AUTOPSY FINDINGS		
w requires that the been signed by tot. of Health and shows any in	MEDICA						PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
> = =	2	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YI	ES NO	UNCERTAI	NE		1 TYES: 2 NO		
has De	CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only one,						
SICIAN: The certificate the State	YSICI	1 TES 2 DHO	HOSPITAL: 1 - Inpatient 2 - ER/Outp	atient 3 DOA	OTHER:	ne 5 🗆 Residence	8 Other (Specify)				
PHY this with	ву РНУ	27. MANNER OF DEATH 1. Netural 8 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	JURY W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURED			
TTENDI TOR: A after d	0	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	atreet, factory, offic	Ca	281. LOCATION (Street City or Town, State	OCATION (Street and Number or Rural Route Number, ity or Town, State)			
DIRIU DIRI	PLE	29a. CERTIFIER (Check only	CIAN: To the best of my knowl	edge, death occurr	ed at the time, date	and piece, and due	to the ceuse(a) and ma	inner as stated.			
THE HOSPITAL THE FUNERAL filed within 72	COMPLET	2 MEOICAL EXAMINE	R: On the basis of exemination						e(s) and manner as stated.		
To the hospita To the funera De fied within 7 IMPORTANT: I	O BE	29b. SIGNATURE AND TITLE OF CERTIFIER	E M	-		29c. LICENSE NU			VED (Month, Day, Year)		
	10	And rew Lazris	charles to	m m	ed (note.	711 Maid	in Choice La				
		31. DATE FILED (Month, Day, Year) OCT 0 4 1995	32. REGISTRAR'S SIGN.	ATURE OF ROLL OF				, , , , ,	, vi ()		
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTA	L HYGIEN					
	1. DECEDENT'S HAME (First, Middle, La						OF DEATH		3	. TIME OF DE	EATH	
	Mary Elizabe					Set	ot. 19	YEAR	1:10	P		
	4. SOCIAL SECURITY HUMBER 214-74-7455	1 □ M 2 🔀 F 94	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Nov	OF BIRTH th, Day, Year) Va 3, 1		Country)	LACE (State or	Foreign	
<u>~</u>	96. FACILITY NAME (II not institution, go Vindabona Nursi				OR LOCATION OF D			9c. COUNT				
5	RESIDENCE OF DECEDENT			Drac	ddock Hg	ts.		Fr	eder	ick		
DIRECTOR	Md.	Frederick	10c. CIT	y, town or loca Mic	ddletown					Od. IHSIDE CI LIMITS? YES 2		
RAL	336 S. Jefferson	n St		10	H. ZIP CODE	^				AT COUHTRY	7	
FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER I	H U.S. ARMED	13. WAS DEC	21769 CEHDENT OF HISPA		M2 (Speakly Voc	U.S.		America	41	
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES	FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES			If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 HD Specify:				s or Ho— 14. RACE — American Indian, Black, Whita, atc. Specify: White		
ETED	(Specify only highest gi	offy only highest grade completed) (Give ki			kind of work done during most of working			BIHESS/IHDU:	STRY			
_	Elementary/Secondary (0-12)	College (1-4 or 5 +)	homemaker				0.7	m hom				
COMP	17. FATHER'S HAME (First, Middle, Last)	18. MOTHER				AME (First,	Middle, Maiden	n hom	е			
BE	Elmer Clayton Routzahn				Madora	a Lee	Stone					
2	190. INFORMANT'S NAME (Type/Print) Elmer E. Adkins	196. MAJLING		and Number or Rural								
	20a. METHOD OF DISPOSITION	200	b. PLACE AHD DATE		line Dr.	, MI			_	21769		
	1 XBurisi 2 Cremetion 3 R 4 Donation 5 Other (Specify)	emoval from State	eformed	ther place)	7	9/2	2 Mid	CATION - CH				
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME A	nd address of FA	CILITY	- D	diero.	WIL	YKL .		
	Vhyla 30M	Mon		31 E.	Main St	M	n rune Halat	own 1	ome wa			
	23. PART —Enter the diseases, shock, Dr heart failured immediate CAUSE (Finel disease or condition resulting in death)	a. CONSUM:	each line.					atory arres			Between nd Death	
ENIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF									
MEDICAL C	Dementia, atrial fibrillation							Ci Oi	ERE AUTOPSY MILABLE PRIO OMPLETION OF F DEATH?	F CAUSE		
	DID TOBACCO USE CON	NTRIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAI	N 🗆			'	YES 2	НО	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	26, PLACE DF OEAT	OTHER:	s 5 🗆 Residence	6 Othe	r (Specify)					
ВУ РНУ	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)					28d. DESCRIBE HOW INJURY OCCURED					
ETED (3 Suicide 6 Could not I 4 Homicide datarmined		— At home, farm, s	itreet, factory, offic		281. LOC City	ATION (Street s or Town, State)	and Number or Rural Route Number,)				
COMPLI		YSICIAN: To the best of my know INER: Do the basis of examination								nd manner sa	stated.	
w	296. SIGNATURE AND TITLE OF CENTS	SIER			29c. LICEHSE HUI	MBER		29d. DATE S	IGHED (M	onth, Day, Yea	c)	
10 B	1/1/0				1/371	78		> /	1-3	-95		
	30. NAME AND APPRESS OF PERSON TO A PARE PLED (Month Day Mark	70	N Q11 C	Acres are a	Brunsi	dric	k m	dó	ורול	6		
	OCT 0 4 19	32. REMISTRAR'S SIGN	SON-Rardall	(

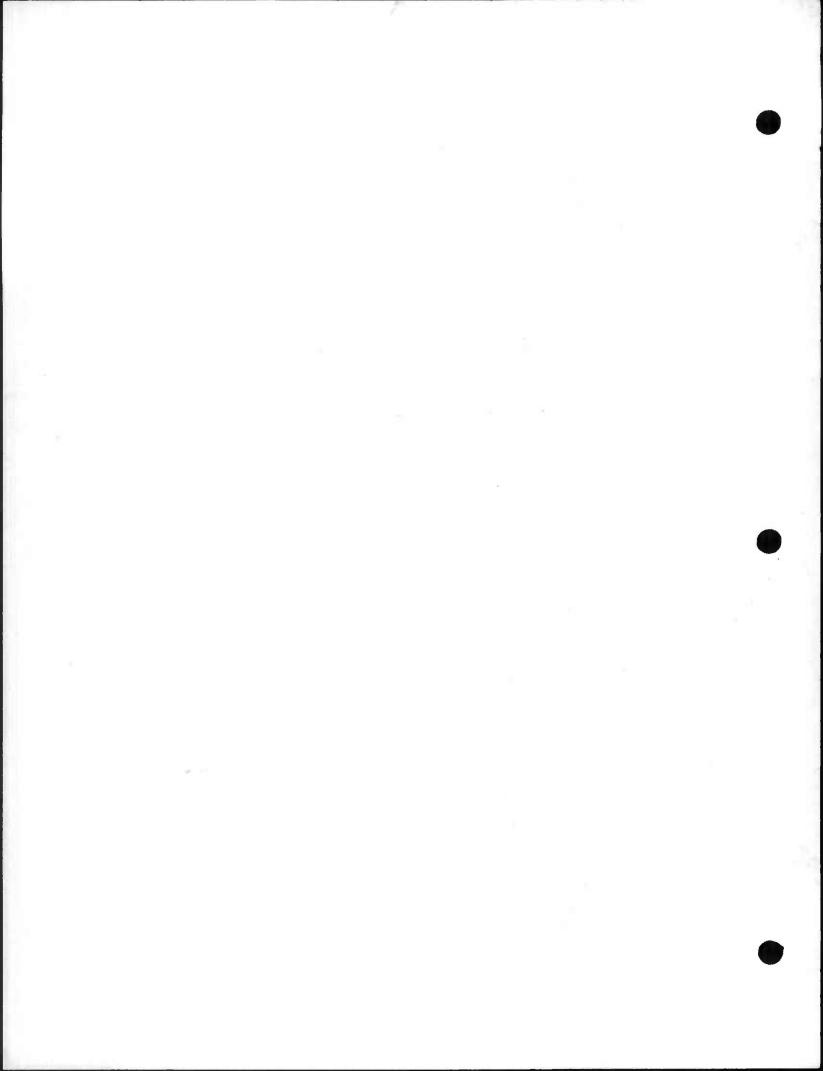


FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) JAMES WELLS BLACK 2. DATE OF DEATH SEPT 29 DAY 995 YEAR 6:20p	м								
	4. SOCIAL SECURITY NUMBER 218-32-2617 S. SEX 91 YRS. SEX 128-32-2617 91 YRS. SEX 91 YRS. SEX 15 UNDER 1 YEAR SE UNDER 24 HRS. NOV 25 1903 Cecilton									
OR	90. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County Elkton 9c. county of Death Cecil									
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY	=								
L DIF	Maryland Cecil Cecilton UMMTS? 1次 YES 2 □ NO									
VERA	167 W. Main St. 21913 U.S.A.									
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married 5 Nover Married 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 Nover Married 5 Nover Married 6 Nover Married 7 Nover Married 7 Nover Married 8 Nover Married 8 Nover Married 8 Nover Married 9									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Appliance Salesman Retail Sales 17. FATHER'S NAME (First, Middle, Last) To have the place of the place										
COM	17. FATHER'S NAME (First, Middle, Last) John H. Black 16. MOTHER'S NAME (First, Middle, Meiden Surname) Millie V. Watts									
TO BE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Chekon (daughter) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Ripple Court Sacramento CA 95831									
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetton 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION/Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town, State									
	21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY	-								
	Box 235 Galena, MD 21635									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart failure. List only one ceuse pn each line. Approximate interval Between									
	immediate cause (Final disease or condition resulting in death) a. Chronic Renal Failure 3 yrs	h								
NO	disease or condition Chronic Remail Failure Due to (or as a consequence of): Sequentially list conditions. b. Carcinoma of Prostate									
CATI	Sequentisity list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									
CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaultling in death) LAST									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
EDICAL	Coronerry Artery Disease PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
Σ	TS Chamie Bowel DISARSE 10 YES 2 NO									
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)	4								
SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Xinpetient 2 ER/Outpatient 3 ODA 4 Nursing Home 5 Residence 6 Other (Specify)	1								
PHYSICIAN:	27. MANNER OF DEATH 26e. DATE OF INJURY (Morith, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED	1								
Э ВУ	2 Accident Investigation Inves	4								
ETED	4 Homicide determined building, atc. (Specify) City or Town, State)									
COMPLET	29e. CERTIFIER (Check only one) 2 Description (Check only one) 2 Description (Check only one) 2 Description (Check only one) 3 Description (Check only one) 4 Description (Check only one) 5 Description (Check only one) 6 Description (Check only one) 7 Description (Check only one) 8 Description (Check only one) 9 Description (Check one) 9 Descri									
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	\dashv								
TO B	Wallace Olean au 100 DO7129. 30 Sept 95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	Wallace Obenshain MD Ches. Fam. Practice Box 415 Cecilton, MD 21913									
- 4	31. DATE FILED TYPIT ON YOUT 1005 32 ASSISTAN'S SIGNATURE	٦								

BALTIMORE, MARYLAND 21215-0020



STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH MONTH Sept 30 SHIRLEY ANN **BIGGS** 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
JULY 28 IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🗆 M 2 😾 F 60 MONTHS DAYS HOURS 220-32-8177 YRS permit. Pages 1, 2, 3 should 99. FACILITY NAME (If not institution, give street and number)
Union Hospital of Cecil Co. 96. CITY, TOWN OR LOCATION OF DEATH EIKTON DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY, TOWN OR LOCATION Cecilton Maryland Cecil FUNERAL 10s. STREET AND NUMBER 10f. ZIP. CODE 125 Rickards St. 21913 page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuben, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 2 XNO BY 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION
173 los kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade compl (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) COMPLE Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) John Boyd Evelyn notified at 띪 196. MAILING ACCRESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code)

Rox 405 Cecilton, MD 21913 19e. INFORMANT'S NAME (Type/Print) 2 Andrew P. Biggs (husband) Box 405 Cecilton, MD 20g. METHOD OF DISPOSITION

20g. METHOD OF DISPOSITION

3 Gremetlon 3 Gremoval from State
4 Donatton 5 Green Courts å 20b. PLACE AND DATE OF DISPOSITION (Name of Jured withmer hours after death. Page 6 m. completely filled in by the funeral director, 1al, cremation, or removal. must Zion Cemetery 10/3/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
Galena Funeral Home of Stephen M00510 d Schaech medical 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Final the disesse or condition Brochiectasis DUE TO (OR AS A CONSEQUENCE OF) resulting in desth) traumatic event, executed and com CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): attending physician a if any, leeding to immediate certificate be cause. Enter UNDERLYING other CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST 0 n signed by the attend I Health and Mental H the death Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL that any pheumonectomy, Respo 1 - YES 2 NO requires shows t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN has be W. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The this certificate h Hem HOSPITAL: OTHER: 1 TES 2 NO DR ATTENDING PHYSICIAN: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO After the BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) DIRECTOR: A hours after de lem 28 ls 90 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 😾 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and manner as stated. COMPL FUNERAL within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER

Wallaca Oleyklaria, M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE
Jalia Skutchen Romal!

31. DATE FILEO (1007), Coy. (ber) 1995

CERTIFICATE OF DEATH

29c. LICENSE NUMBER

Wallace Obenshain MD Ches. Fam. Practice Box 415 Cecilton, MD 21913

D07129

95 31218 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH 1995 YEAR 4:52am 8. BIRTHPLACE (State or Foreign Country) 1935 Maryland 9c. COUNTY OF DEATH Cecil 10d. INSIDE CITY 1 X YES 2 | NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: white 16b. KIND OF BUSINESS/INDUSTRY Spencer 20c. LOCATION — City or Town, State Cecilton, Box 235 Galena, MD Approximata Interval Between Onset and Death 48415

DHMH-18 Rev 1/89

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE

1 TYES 2 TNO

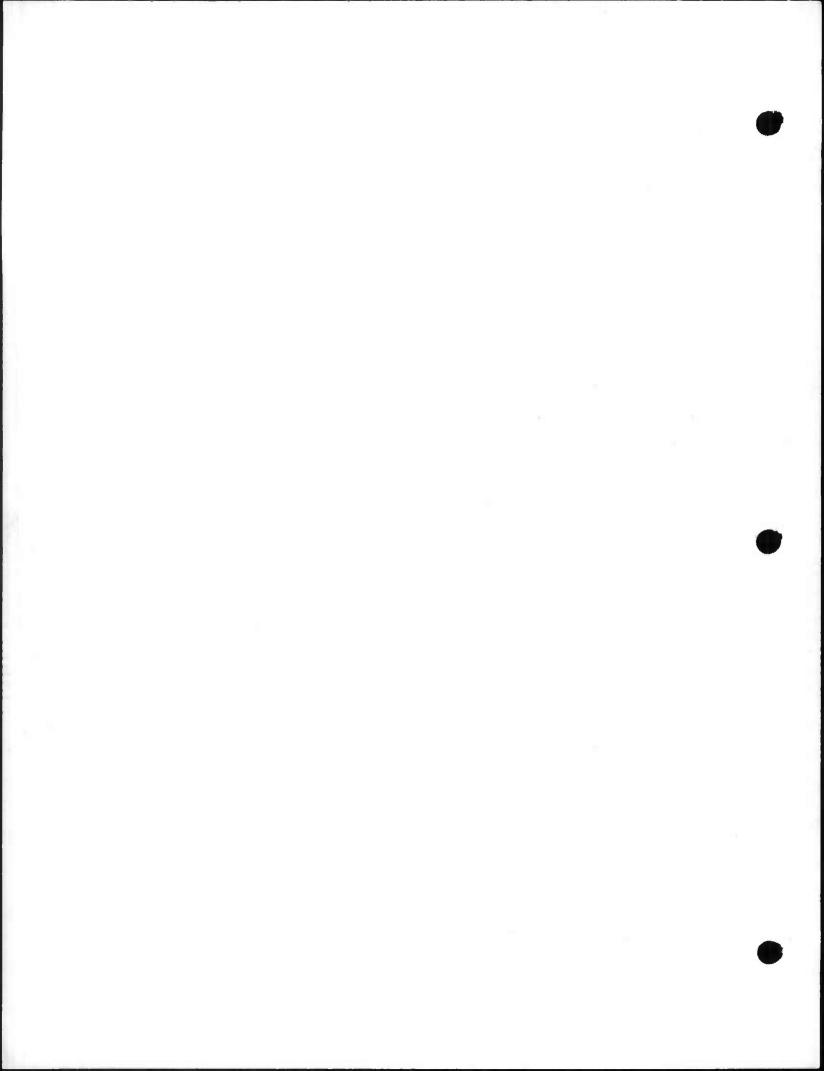
OF DEATH?

29d. DATE SIGNED (Month, Dev. Year)

30 Sept 95

BE

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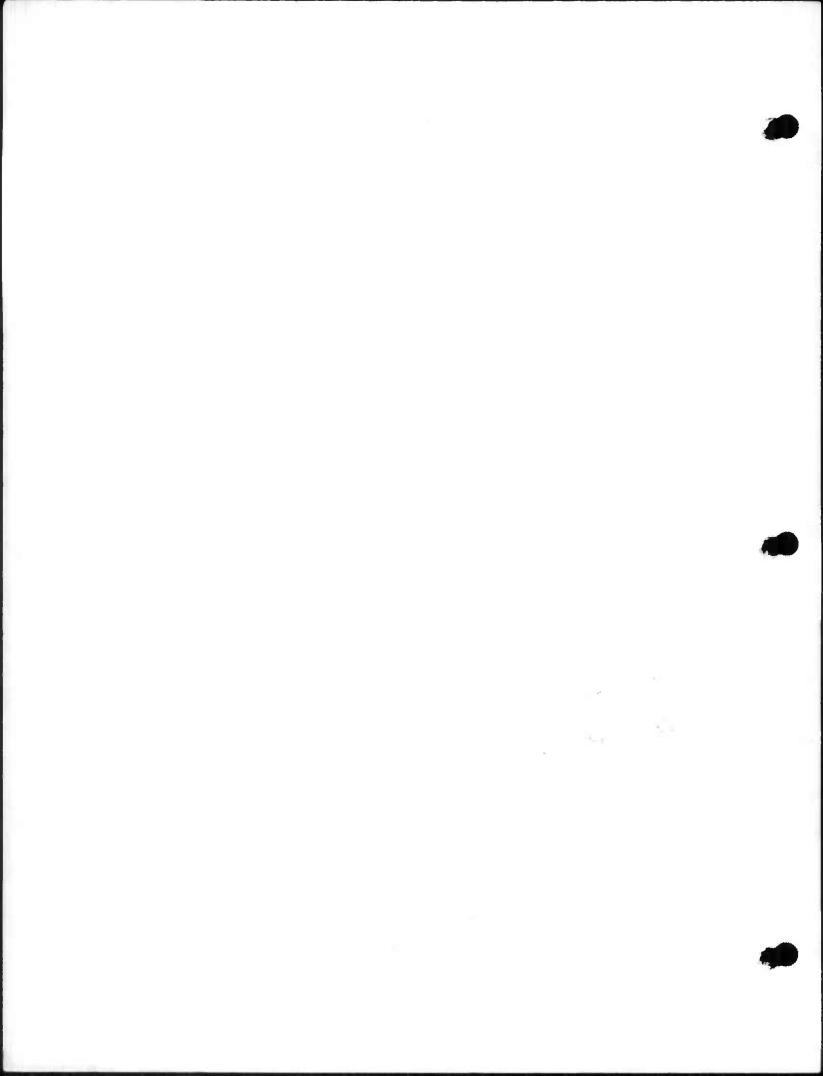


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a pure after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

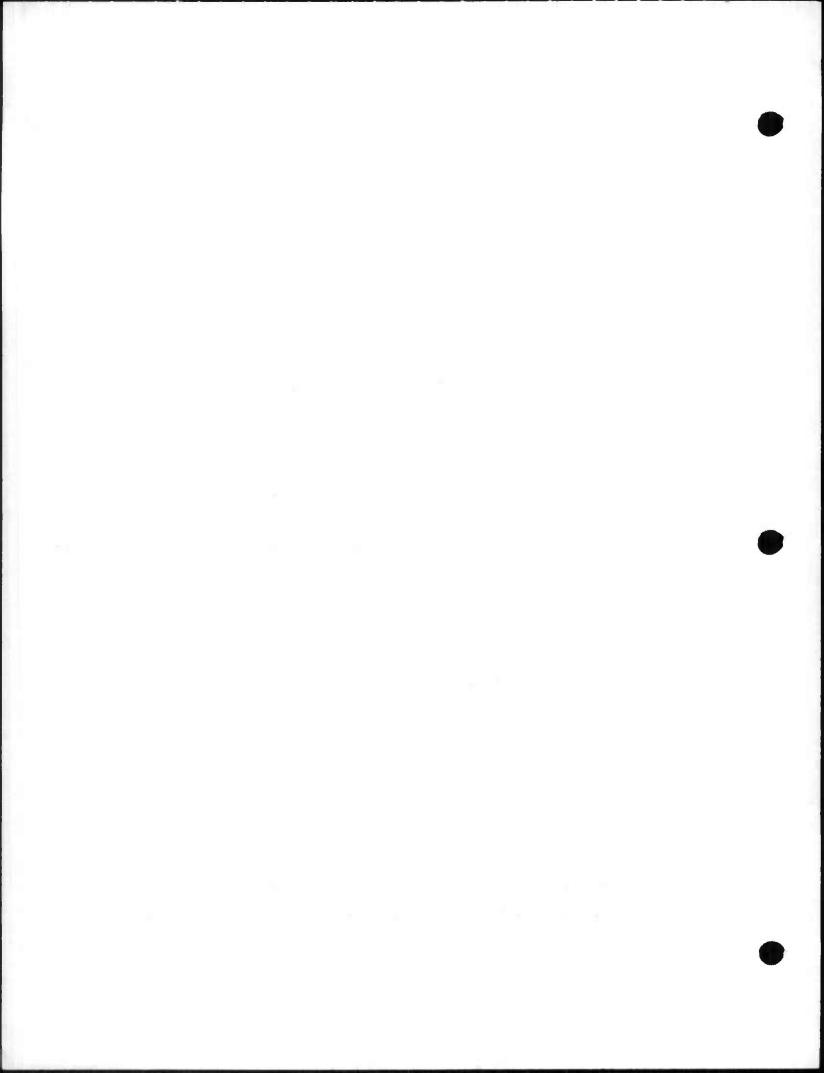
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

	1 - FOR STATE REGISTRAR	TE OF MARYLAI			HEALTH AN		HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		1				DATE OF DEATH	YEAR	3. TIME OF DEATH		
	William E. Brid					44	9- 21-		01:35 A™		
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. liest birthday) 154-20-6808 1√2 M 2 □ F 7.2 YRS. MONTHS DAYS HOURS MIN						Cou	RTHPLACE (State or Foreign intry)		
	9a. FACILITY NAME (If not institution, give street and it	12	9b. CITY, TOWN OR LOCATION O				3 - 19-1923	9c. COUNTY OF	Maryland DEATH		
E I	Union Hospital	,		E1kto				Cecil			
5	RESIDENCE OF DECEDENT	· · ·									
DIRECTOR	10a. STATE 10b. COUNTY Delaware New Castl		35.00	, TOWN OR LO	100				10d. INSIDE CITY LIMITS?		
	Delaware New Cast	Le	M1	ddleto	WII 101, ZIP COOE			10a. CITIZEN O	1 X YES 2 NO		
RA	132 East Lake Street	r .			19709			USA			
FUNERAL	11. MARITAL STATUS 12. WAS	R DECEMENT EVEN IN I	J.S. ARMED		DECENDENT OF HI		RIGIN? (Specify Year		ACE — American Indian, lack, White, etc.		
BY F	1 Never Married 2 Married 1 Victoria Married	CES? 1 YES	ZX_NO ES		, specify Cuban, Ma YES 2 NO S	exican, Pu Specify:	iarto Hican, atc.)		Black		
	15. DECEDENT'S EDUCATION		I6a. DECEDENT'S	HEILAL OCCUE	ATION		16b. KIND OF BUSI	MESS/INDI ISTER			
COMPLETED	(Specify only highest grade complete	d) e (1-4 or 5 +)	(Give kind of v	vork done during	most of working		100. KIND OF BUSI	MESS/MUUS I KI			
PL	Unknown 0	(1-4 0/ 5 +)	N	Ma i l Ca	arrier		Posta	al Serv	ice		
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	S NAME (First, Middle, Maiden S	Sumame)			
BE (idals			Ann	ie	Unknown				
2	19a. INFORMANT'S NAME (Type/Print)						Number, City or Town,				
	Bryant Waters	Lan							ware 19709		
	20a. METHOD OF DISPOSITION 1 Durisi 2 Cremation 3 Removal from	n State (other place)		cometery, cremetory			ATION — City or			
	4 Donstion 5 Other (Specify) Trinity UAME Church Cemetery Millington, MD 21. SIGNATOR OF FUNERAL SERVICE CEMBER 22. NAME AND ADDRESS OF FACILITY D										
	22. NAME AND ADDRESS OF FACILITY Ernest M. Congo Funeral Hon P.O. Box 2593, Wilm., DE 19805										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate										
	ehock, or heert fellure. List only one cause on each line.										
à.	Manager and Miles										
	reculting in deeth) a. Mctustaka alung caranana & Hulura DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions b.										
E	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
	CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	that initiated eventa resulting in death) LAST										
S							LI. 24a. WAS AN A				
CAL	PAHI II. Uther aignificant conditions contri	ibuting to death but	t not resulting	esulting in the underlying couse given in Part I.				MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
							1 [] YES 27	NO NO	OF DEATH?		
M							.		1 YES 2 NO		
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL			2	6. PLACE OF DEAT	H (Check o	only one)				
SIC	EXAMINER? 1 VES 2 NO IN In	PITAL:	tient 3 DOA	OTHER:	Home 5 - Reside						
Ή		In. DATE OF INJURY (Month, Day, Year)	26b. TIM		INJURY AT WORK?		d. DESCRIBE HOW IN	JURY OCCURED)		
BY F	1 Netural 5 Pending 2 Accident Investigation	(month, bay, roay			YES 2 N	0					
	3 Suicide 6 Could not be	At home, farm,	street, factory,	office	261	t. LOCATION (Street as City or Town, State)	nd Number or Rui	ral Route Number,			
ET	4 Homicide detarmined										
AP.	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To										
COMPLETED	2 MEDICAL EXAMINER: On the	e basia of examination	and/or investigation	on, in my opini							
BE	29b. SIGNATURE AND TITLE OF CERTIFIER						7 - DE		NED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMP	LETED CAUSE OF DEA	TH (ITEM 27) (Tona	Print)	Cioo	U133	,	8/2	HV		
	Kenneth S. Lewis, 1				letown,	DE	19709				
								-			
	SEP 2 8 1995 Julia akuslian-Ranfall										

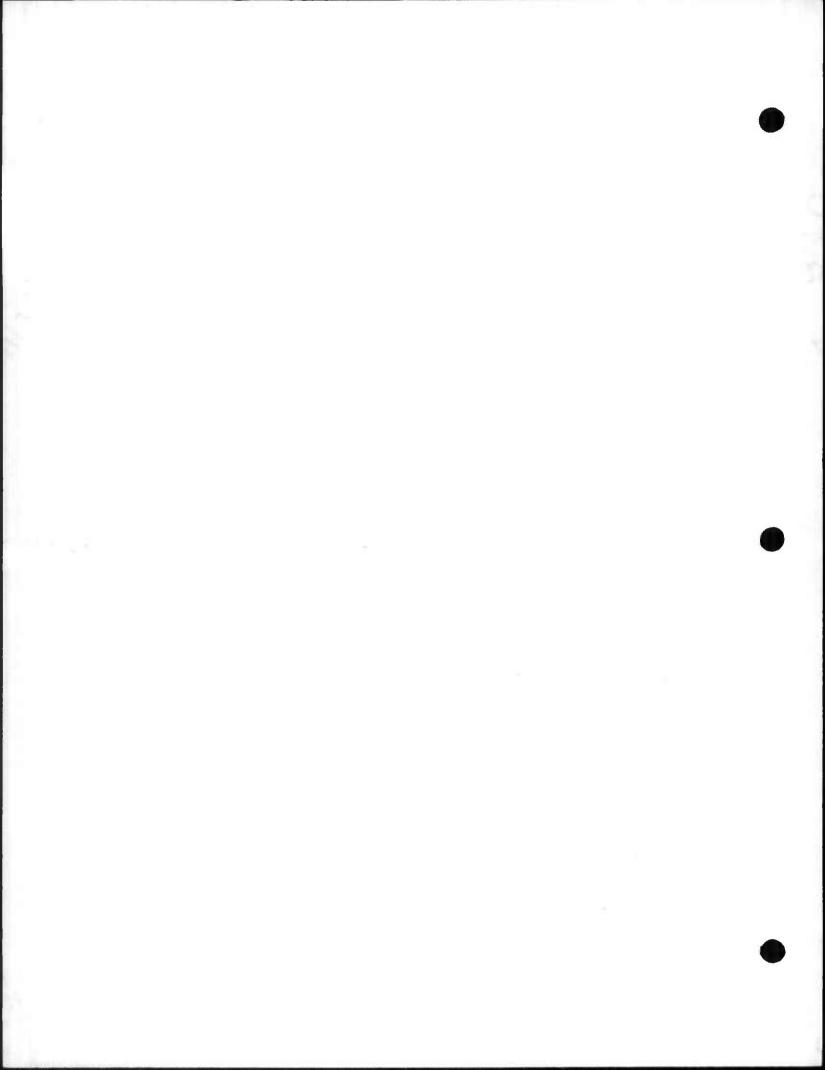


DIVISION OF VITAL RECORDS

		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENI REG. NO.	E					
		1. DECEDENT'S NAME (First, Middle, Last) EDWIN EARLE BROWN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In ure last birthday) ELINGEN VERN ELINGEN VERN	2. DATE OF DEATH MONTH DA	95 1-15 FM					
should		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 90. FACILITY NAME (If not institution, give street end number) 90. FACILITY NAME (If not institution, give street end number) 90. FACILITY NAME (If not institution, give street end number)	7. DATE OF BIRTH (Morth, Day, Year) 12-/5-0	BIRTHPLACE (State or Foreign Country) Poc. COUNTY OF DEATH					
1, 2, 3	CTOR	430 AVENEL CINCLE WESTMINS?	- 4	CANNOIL					
permit. Pages	AL DIRE	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION WESTMINSTE 10e. STREET AND NUMBER 10f. ZIP CODE	R	10d, INSIDE CITY LIMITS? 1 YES 2 NO					
rian. -transit	FUNERA	430 AVENE CINCLE 2115	SINIC ORIGIN? (Specify Ves	or No — 14. RACE — American Indian,					
attending physicse as the burial	BY	1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexic 1 YES 2 NO If YES 2 NO IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify Cuben, Mexic 1 YES 2 NO Specify Cuben, Mexic 1 YES 2 NO Specify Cuben, Mexic 1 YES 2 NO Specify Cuben, Mexic 1 YES 2 NO Specify Cuben, Mexic 1 NO Specify Cuben, M	en, Puerto Rican, atc.)	Black, White, etc. Specify: Wh (#E					
5 5	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	16b. KIND OF BUS	INESS/INDUSTRY					
d be detached to	ш		AME (First, Middle, Maiden S	turneme) La France					
ay be retained page 5 should be notified	TO B	MANY BROWN BRYSON F.O. Boy 868	Poute Number, City or Town	State, Zip Code) 1. Med 21157					
Tector.		20b. METHOD OF DISPOSITION 1 Duriel 2 Cremellon 3 Removal from State 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22b. PLACE AND DATE OF DISPOSITION (Name of cemelary, crematory or other piace) (1) DATE OF DISPOSITION (Name of cemelary, crematory or other piace) 22b. PLACE AND DATE OF DISPOSITION (Name of cemelary, crematory or other piace) 22b. PLACE AND DATE OF DISPOSITION (Name of cemelary, crematory or other piace)	10/3 4/4	EATION - City or Town, State MOSTERAL, MA					
0 = 0		23 PAST I Fotor the Places of complete profits and the last First Jules of Minister, Md							
red within 24 hours after completely filled in by the hall cremation, or removal.		abock, or near fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE TO YOCAZA A LAPARCH CONTROL OF STORY OF A CONSEQUENCE OF:	ch aa čérdiec or reapir	Approximate Interval Setween Onset and Death					
th certificate be executed ending physician and con I Hygiene prior to burial.	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
w requires that the dea s been signed by the att pt. of Health and Menta 3 shows any injury,	MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in	PERFORI	MED? AVAILABLE PRIOR TO					
The la	YSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:	N 🗆						
PHYSICIAL this certifi with the	표	1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY WORK? 1 Netural 5 Pending M 1 VES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED					
TTENDI CTOR: A after de 28 is	TED BY	2 Accident Investigation 3 Suicide 8 Could not be distermined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify)	28f. LOCATION (Street or City or Town, State)	nd Number or Rural Route Number,					
425	COMPLE	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and duration one) MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the							
TO THE HOSPITA TO THE FUNERA De filed within 7 MPORTANT: 1	то ве	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NU 29c. LICENSE NU D316 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	MBER GO	29d. DATE SIGNED (Month, Day, Year)					
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	e WESTA	WILL OW SAISHIN					
		OCT 05 1995 Julia Studen Revolate							



		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT DF H		TENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last		lliam	Baker		2. DATE OF DEATH	AV W	3. TIME OF DEATH 2.09 PM	
P		4. SOCIAL SECURITY NUMBER 215-36-8179	5. SEX 8. AGE	(In yrs. lest birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) Feb. 11,	8.	BIRTHPLACE (State or Foreign Country) [aryland]	
2, 3 should	ECTOR	9a. FACILITY NAME (If not institution, give 3411 Harney Road			96. сіту, тоwn с Taneyt	OR LOCATION OF DE	ATN	9c. COUNTY Carr	OF DEATH	
. Pages 1,	DIREC	Maryland Car	roll		ry, town on Local	TION			10d. INSIDE CITY LIMITS? 1 YES 2 1 NO	
i. Insit permit.	ERAL	100. STREET AND NUMBER 3411 Harney Road				1. ZIP CODE 2178	7	10g. CITIZEN	OF WHAT COUNTRY?	
1215-0020 r attending physician. use as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yes, sp		C ORIGIN? (Specify Yes, Puarto Rican, etc.)		RACE — American Indian, Black, Whita, atc. Specify: Caucasian	
D 21 spital or ed for	PLETED	15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) 5th	OUCATION de completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATION work done during mo se retired.)	ON ost of working	Agricu	SINESS/INDUST		
YLA by the be de	E COMPL	17. FATHER'S NAME (First, Middle, Last) George Willi	am Baker			18. MOTHER'S NAM Blanch	E (First, Middle, Maiden	Surname)	armon	
iE, MARYL ay be retained by the page 5 should be one of the at the page 5 should be at the page 5 sho	TO B	19a. INFORMANT'S NAME (Type/Print) Grace E. Baker		3411	Harney R	Road Tan	oute Number, City or Tow Sytown, Ma	ryland	21787	
MOR e 6 m rector.		20a. METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Raid 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	movel from State cerr	netery, cremetory or o Baust U.C	other plece) C. C. Ceme	ement etery ND ADDRESS OF FAC	10/7 Ty		Maryland	
BALTIN hours after death. Pag ed in by the funeral di or removal. medical examiner		Skiles Funeral Home Taneytown, Md 21787								
in 24 biy fill attion,		shock, or heart fellure immediate CAUSE (Finel disease or condition resulting in death)	a. CARO	each line.	YOPA		an cardiac or reapi	ratory arrest,	Approximate interval Between Onset and Death	
certificate be executed of the properties of the properties of the principle of the princip	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	f):					
records requires that the sen signed by the of Health and Michaelth	MEDICAL CE		OBSTRUCE AOR	TIVE	STEN	MONAR	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
E 88 F	'SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEAT	TH (Check only one) OTHER:	UNCERTAIN				
ATTENDING PHYSICIAN: ECTOR: After this certifical s after death with the St.	ву Рну	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation			IE OF 28c. INJI	URY AT PRK? YES 2 NO	28d. DESCRIBE NOW II	NJURY OCCURE	ED	
OR ATTENDI OIRECTOR: A hours after di	LETED	3 Suicide 6 Could not be detarmined	building, are (open	спу)			281, LOCATION (Street a City or Town, State)		ural Route Number,	
HOSPITAL FUNERAL WITHIN 72 FANT: IF	COMPL	(Check only CERTIFYING PHYS	SICIAN: To the best of my knowl			eath occured at the 1	me, data and place, and	d dus to the ca		
TO THE DE filed IMPOR	TO BE	NAME AND ADDRESS OF PERSON W	Kary	MD ATN (ITEM 27) (Type	Print)	MO ZZ	239E	▶ 10	MED (Month, Day, Year) 5/5/95	
		JOHN R. KA	LLOY MI	0 6		SBURG	, PA,	173	25	
		31. DATE FILED (Month, Day, Year)) julia d'audece	Revolate						



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

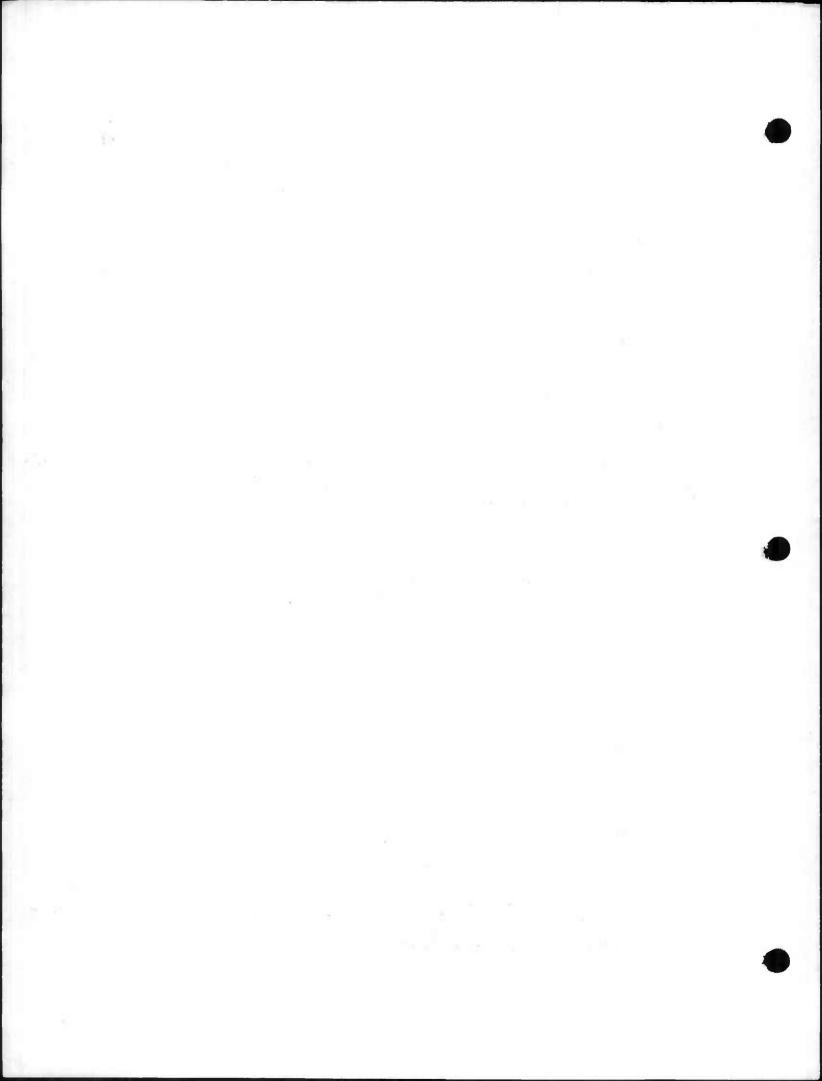
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the forms after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. which 24 hours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF	MARYLAND	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	ENE
	С	ERTIFICATE	0	F DEAT	H		REG.	NO.

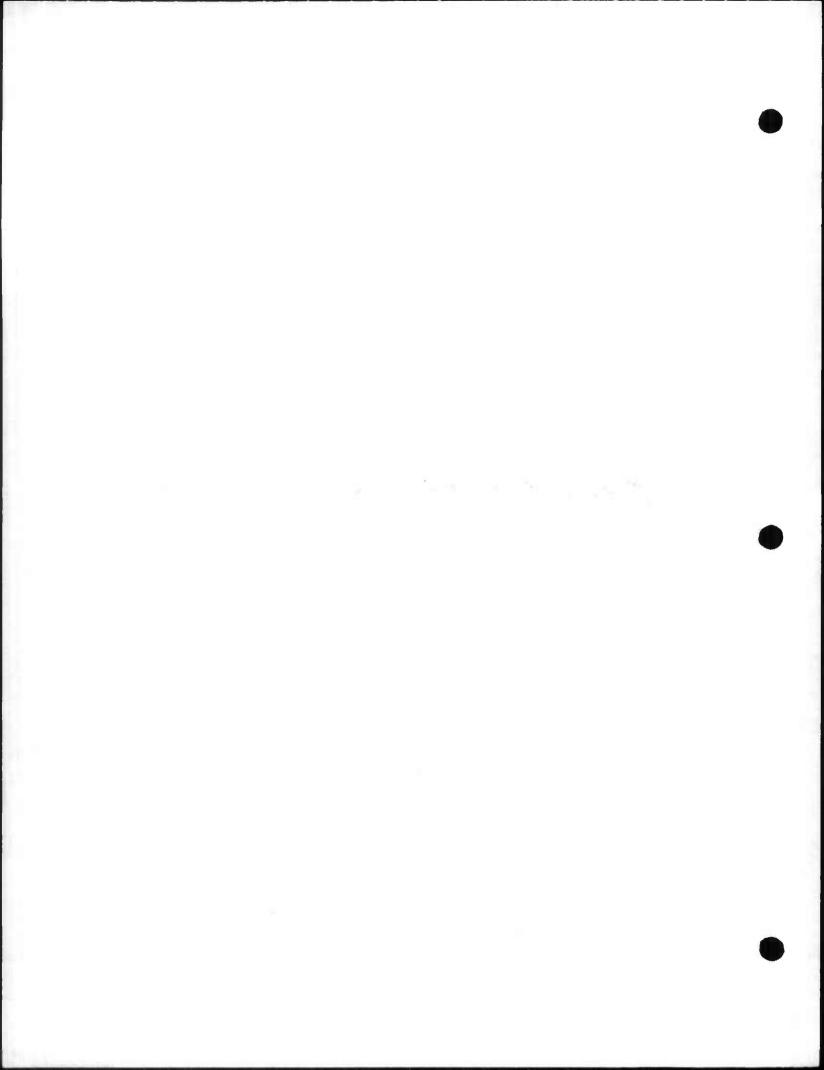
Burna Brown Brewer Scala Scunity Number S. SEX O. AGE (in yrs. lest birthday) VERN SCHAL SECURITY NUMBER S. SEX O. AGE (in yrs. lest birthday) VERN A 1 Mary Sept 27, 1995 4:30 P SCALA SECURITY NUMBER S. SEX O. AGE (in yrs. lest birthday) VERN MONTHS DAYS MONTHS FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM				HYGIENE BEG. NO.		
BUILD A BY OWN SOOMS SCHUMT NUMBER SOOMS SCHUMT NUMBER SOOMS SCHUMT NUMBER 40-26-4011 1	DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH	
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MANNER OF DEATH	EXAMINER?	HOSPITAL:	10					
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(Check only Light Prinsip Prinsipal: to the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and manner as stated.								
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NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (NAME AND ADDRESS OF PERSON WHI	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri	nnt)	1			
Jeffrey E. Atkinson, MD 780 Ritchie Huy Severn Parking	Jeff new E	. A+Kin	Can M.	1.	780 RH	tehiot	Yny Sen	en Pur Win
DATE FILED (Month, Day, 1667) 32. REGISTRAR'S SIGNATURE A. Atheretical Resolution		32. REGISTRAR'S SIGNA	ATURE	-	V- V- (



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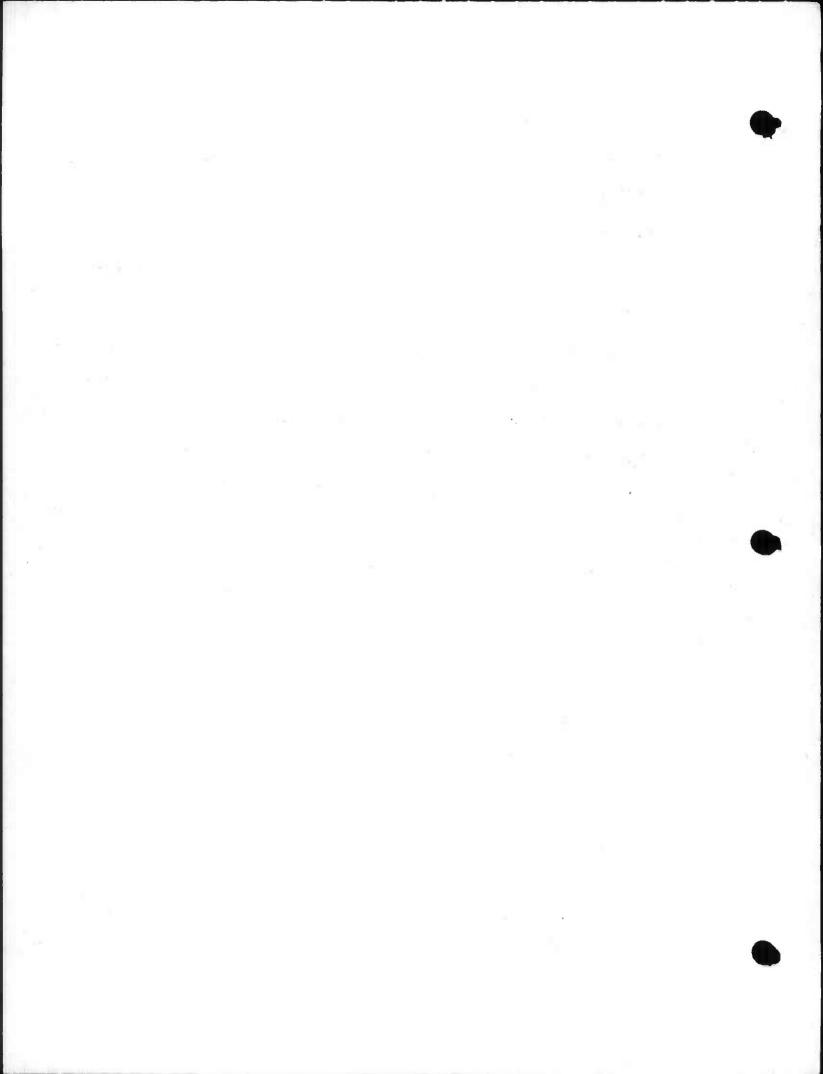
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

					AIEU			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3	. TIME OF DEATH
	LENA	IDA BAI	KER				MONTH			YEAR	C-20 3
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGI	E (In yrs. lest b	irthday) IF	UNDER 1 YEA	R IF UNDER 24 HRS.	SEDL	ember			ACE (State or Foreign
	202-05-1811	1 M 2 X F	88		NTHS DAY		(Month	, Day, Year)		Country)	
			00	1000				mber 6,			sylvania
~	9a. FACILITY NAME (If not institution, give	street and number)		96.	. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUNT	Y OF DEA	ТН
DIRECTOR	Salisbury Nursing	g & Rehab. Co	enter		Salie	sbury			Wio	omic	_
5									VATO	OHILC	0
2	10a. STATE 10b. COUN		18	10c. CITY, TO	OWN OR LO	CATION				1	Od. INSIDE CITY LIMITS?
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7	10e. STREET AND NUMBER					10f. ZIP CODE			10a. CITIZE		AT COUNTRY?
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FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN ILC ADM	· n	1 40 1110 1						
디	1 Never Married 2 Married	FORCES? 1 YES	8 2 X NO		If yes,	ECENDENT OF HISPA specify Cuban, Maxic	NIC ORIGIN an, Puerto F	? (Specify Yes lican, etc.)	or No—	Black, 1	- American Indian, White, etc.
à l	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		1 🗆 1	ES 2 K NO Speci	ly:		- 1	Specify:	
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COMPL	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	AME (First, A	ficicle Maiden S	Sumama)		
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B	19a. INFORMANT'S NAME (Type/Print)	KIIIIE	1								
2						et and Number or Rural					
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	20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Res	mount from State	Db. PLACE AND	DATEOFDE	ISPOSITION	(Name of	DATE	20c. LOC	ATION - CIT	y or Town	, Stata
	4 Donation 5 Other (Specify)	moval from Stata	Beth I	tory or other p	olacei Ceme	terv	9/	27 5.	alisb	irv	MD
	21. SIGNATURE OF FUNCEAL SERVICE L	ICENSES 0		or de a		AND ADDRESS OF FA			41100) ,	
- 1	11/1/ 21	1/2011				lloway Fu		1 Home			
		408 WILL	us		1000	I Snow H			Lighu	eur 1	m 21801
	23. PART I. Enter the diseases, or	complications that plus	ed the death	h. Do not e	order the	mode of duino au	h as card	inc or monte	atom: areas	. , , .	
- 1	MINOCK, OF HEART TAILUTE	List only one cayse on	pach line.			nous in cynig, sec	or se cere	tec or respir	atory arres	10.	Approximate Interval Between
- 1	IMMEDIATE CAUSE (Final	-0/)								Onset and Death
- 1	disease or condition resulting in death)	. aleto	in	20	0 5	Dines	-	_			1
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E	that initiated events	DIJE TO (OR AS	A CONSEQUE	ENCE OF)							1
CERTIFICATION	resulting in death) LAST	d.									
8	_	-									T.
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3 II	PART II. Other significant condition	ens contributing to death	but not res	ulting in th	te underly	ing cause given in	Part I.	24s. WAS AN A		240. W	ERE AUYOPSY FINDINGS
≃ ॥	PART II. Other significant condition	ns contributing to death	but not res	ulting in th	te underly	ing cause given in	Part i.	PERFORM	AED7	IN	AILABLE PRIOR TO
ă	PART II. Other significant condition	ens contributing to death	but not ree	ulting in th	te underly	ing cause given in	Part i.		AED7	AN CC	
								PERFORM	AED7	OF OR	AILABLE PRIOR TO DIPLETION OF CAUSE
ΣĮ	PART II. Other significant condition							PERFORM	AED7	OF OR	ARABLE PRIOR TO DIPLETION OF CAUSE DEATH?
ΣĮ	DID TOBACCO USE CONT 25. WAS CASE HEPERINDS TO MEDICAL		OF DEATH		□ NO	☐ UNCERTAI		PERFORM	AED7	OF OR	ARABLE PRIOR TO DIPLETION OF CAUSE DEATH?
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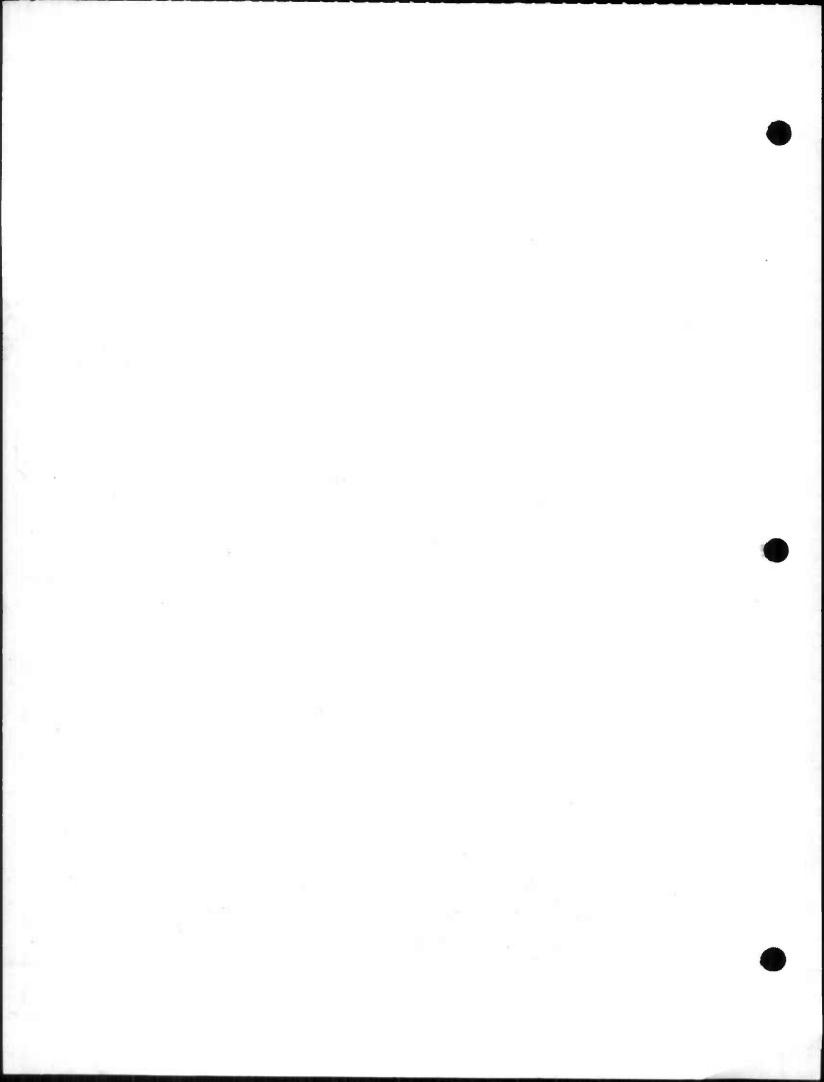
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		1 - STATE OF MA	ARYLAND / DEPAR CERTIF	RTMENT OF H		MENTAL HYGIENI REG. NO.	Ε		
		1. DECEDENT'S NAME (First, Middle, Last) Ronald Brittingham		*****		2. DATE OF DEATH DA Sept. 2	6 1995	3. TIME OF DEATH 2:40 a.m	
2. 3 should		219-82-5243 ¹\XM2□F	8. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4-15-195	Cou	THPLACE (State or Foreign nitry) M.D.	
	стов	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DEER 'S HEAD CENTER SALISBURY WICOMICO							
-	DIRECT	10a. STATE 10b. COUNTY	10c. CIT	TY, TOWN OR LOCAL				10d. INSIDE CITY LIMITS?	
it permit.	AL	MD. WICOMICO 100. STREET AND NUMBER		SALISB1	f. ZIP CODE		N. I.	tX YES 2 □ NO WHAT COUNTRY?	
ing physician. the burlal-transit permit. Pages	BY FUNER		EVER IN U.S. ARMED YES 2 V NO R OR DATES	If yes, sp		IIC ORIGIN? (Specify Yes n, Puerte Ricen, etc.)	Bis	CE — American Indian, lock, Whita, etc.	
al or attend for use as	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of life. Do NOT us		ost of working	16b. KIND OF BUS			
by the hospital be detached to at once.		1 2 17. FATHER'S NAME (First, Middle, Last)		ORAL W	18. MOTHER'S NA	ME (First, Middle, Malden		ERVICE	
retained by 5 should be notified at	TO BE	WENDELL BRITTINGHAM 15a. INFORMANT'S NAME (Type/Print)	19b, MAILING		and Number or Rural I	DRED MARS	n, State, Zip Code)	21052	
ay be		MILDRED BRITTINGHAM 20a. METHOD OF DISPOSITION 1 □ Burlel 2 ★ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify)	20b. PLACE AND DATE cemetery, crematory or o CAMBRID	OF DISPOSITION /N	me of		CATION — CHy or	Town, State	
r death. Pag e funeral dir al.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	mal	22. NAME A	ND ADDRESS OF FA		= 54	Isbur Ma	
confincts to executed with hours after fing physician and completely filled in by the typiene prior to burial, cremation, or removal other traumatic event, the medical	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	e on each line. e d immuno a as a consequence of Opportun or as a consequence of Opportun or as a consequence of Opportun or as a consequence of Opportun or as a consequence of Opportun	deficie listic :			atory arreat,	Approximate / interval Between Onset and Death 2 years	
requires that the death open signed by the attend to thealth and Mental Hishows any Injury, or	MEDICAL CER	PART II. Other algnificant conditions contributing to d	eath but not resulting	In the underlyin	g cause given in	Part I. 24a. WAS AN. PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AMRLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
The law te has b ate Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO			LACE OF DEATH (Ch				
PHYSICIAN this certifi with the	BY PHYS	27. MANNER OF DEATH 1 XNeture: 5 Pending 29s. DATE OF III (Month, Day)		JURY 28c. INJ	HURY AT DRK? YES 2 NO	8 Other (Specify) 28d, DESCRIBE HOW IN	JURY OCCURED		
TTENDI TDR: A after d	ED	2 Accident investigation 3 Suicide s Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							
世 対 な 単	COMPLE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of m						e(e) and manner ee stated.	
TO THE HOSPI TO THE FUNEF be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE	40		D1627			26. 95	
		M. Shrestha, M.D., P. 31. DATE FILEO (Month, Day, Ybar) 32. REGISTRAR	O. Box 20		lisbury	, MD 218	02-201	.8	
0			welsor Rardell						



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22	y fill	the
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached any within 70 hours after heart with the State harm of Health and Mental Horiene nior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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•	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF			YGIENE EG. NO.		
	1. OECEDENT'S NAME (First, Middle, Lest)					2. DATE OF D	EATH		3. TIME OF CEATH
	IRENE	ELIZABETH		BRANIECK	Т	Sentemb	er 21.199	YEAR	7:30 a ^M
1	4. SOCIAL SECURITY NUMBER 5	. SEX 8. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTH		HPLACE (State or Foreign
į	220-32-9071 1 9e. FACILITY NAME (if not institution, give stree	□ M 2 □ F 82	YRS.	MONTHS DAYS	OR LOCATION OF D	July 1	3, 1913		w York
æ	502 Douglas Rd.	(end namber)		Salis		EAIN		icomi	
DIRECTOR	RESIDENCE OF DECEDENT			Salis	bury		l W.	LCOIII	.00
R	10e. STATE 10b. COUNTY		4,7	Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?
		comico	S	alisbury					1 X YES 2 NO
AAL	10e. STREET AND NUMBER			10	r. ZIP CODE				WHAT COUNTRY?
FUNERAL	502 Douglas Rd.	2. WAS DECEOENT EVER IN	ILC ADMED	10 40 00	2 180 1 CENDENT OF HISPA	NIC OBIOING #		JSA	CE — American Indian,
BY FU	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, a	pecify Cuben, Mexico S 2 NO Specific	en, Puerto Ricen		Spec	ck, White, etc.
	15, OECEDENT'S EDUCAT	TION	16e. DECEDENT'S	USUAL OCCUPAT	ION	18h. KIN	D OF BUSINESS/I		ite
COMPLETED	(Specify only highest grade co-	mpleted) College (1-4 or 5+)		work done during m		100. 1010	D OF BOOMEGON		
PL	8	College (1-4 or 5+)	Seamst	ress		Sh	irt Mfg.	. Co.	
ON	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		e, Maiden Surname		
BEC	Leon Ju	ızdowski			Rose		Zyngi	ier	
0	19a. INFORMANT'S NAME (Type/Print)				end Number or Rural				
	Thomas J. Braniech				Rd., Sal				
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove	of from State ceme	tery, crematory or o	OF DISPOSITION (A		DATE	20c. LOCATION		
	4 Donation 5 Other (Specify)	ISEE A S	pringhi	11 Memor	y Gardens	9/25	Hebro	on, M	D
	1/1/11)	11/10		Hol	loway Fu	neral H			/
	W. Cakeel	Helloce	acy						MD 21801
	23. PART i. Enter the diseases, or cor ehock, or heert fellure. Lie			not enter the m	ode of dying, au	ch aa cerdiac	or respiretory	arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Coudance Ary Lythumas Due to (or as a consequence of):								Onset and Death
	resulting in death) a.		MACIC	TTYY	hythu	vias			2A45
	_	C 3	- link	mopil	H				months
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUÊNCE O	(F):					
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury			<i>y</i>					
E	that initiated events	OUE TO (OR AS A	CONSEQUENCE (OF):					
H	reaulting in death) LAST			_					
AL C	PART II. Other eignificent conditions	contributing to death bu	it not resulting	in the underlyl	ng ceuae given ir	Part I. 24e	. WAS AN AUTOPS	3Y 24	Ib. WERE AUTOPSY FINDINGS
						1	PERFORMED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
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PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPIAL:	8. PLACE OF DE	ATH (Check only one)				
YSI	1 TYES 2 TO MO	E-Impetient 2 ER/Outpe	ntient 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Reeldence	8 Other (Sp	ecity)		
H	27. MANNER OF DEATH 1 Partial 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY W	IJURY AT ORK?	28d. DESCRI	BE HOW INJURY	DCCURED	
BY	2 Accident Investigation				YES 2 NO				
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci		street, factory, off	Ice		N (Street and Num wn, State)	ber or Rural	I Route Number,
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICI.	AN: To the best of my knowle	edge, death occur	red at the time, de	te end plece, end du	e to the ceuse(e	end manner ee	stated.	
MO	one)	On the besie of examination	end/or investigat	lon, in my opinion,	death occured at th	e time, date and	place, and due to	o the couse	e(e) end manner ee stated,
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	12			29c. LICENSE NU		29d. 0	DATE SIGNE	ED (Month, Day, Year)
TO B	N FA	400	,		D36	783		9-	21-95
		ET LETO	TH (ITEM 27) (Typ		nc,s	ALISI	suny,	mi	21861
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S, SIGNA	TUDE		t		-		
	SEP 25 1995	Julia danceles	Martalle						

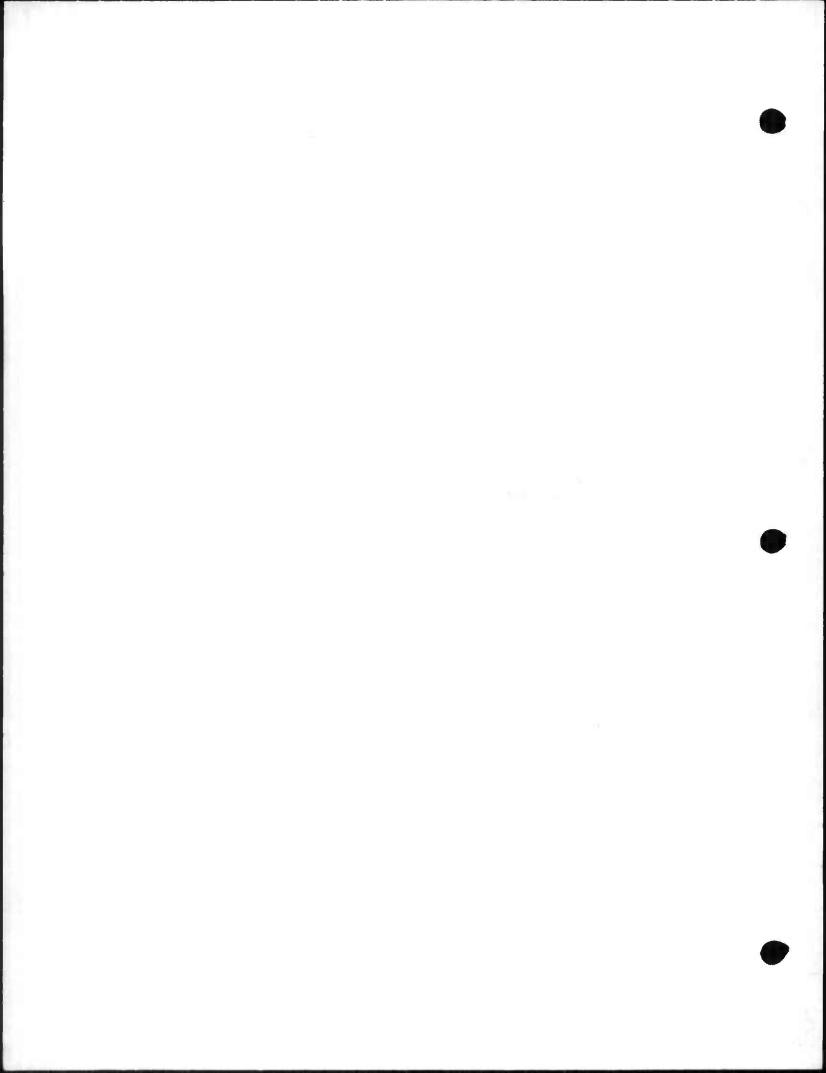


BALTIMORE, MARYLAND 21215-0020	The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should eitled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	em 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic even	

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT S NAME (FIRST, MIDDIE, LIST)							DATE OF DEATI			3. TIME OF DEATH
	MARJORIE LOU	TISE	BAK	ŒR				eptember	20. 19	95	3:55
			AGE (In yrs. In	est birthday)	IF UNDER 1 YE	AR IF UNDER 24	HRS. 7. 1	DATE OF BIRTH		8. BIRTNI	PLACE (State or Foreign
	222-16-5519	□ M 2 □ F	66		IONTHS DA	rs Hours		Month, Day, Year tober 5		Country	aware
	9e. FACILITY NAME (If not institution, give stree	et and number)			Pb. CITY, TO	VN OR LOCATION		roner)		UNTY OF DE	
BC	4954 Nutters Cros	s Rd				lisbury					
DIRECTOR	4954 Nutters Cros	o mu.							I W	icimi	
Ⅱ	10a. STATE 10b. COUNTY				TOWN OR LO						10d. INSIDE CITY LIMITS?
		omico			Salisb						1 TES 2 NO
3AL	10e. STREET AND NUMBER					101. ZIP CODE			10g. Cl	TIZEN OF W	HAT COUNTRY?
FUNERAL	4954 Nutters Cros					2 180)]			USA	
크	11. MARITAL STATUS 1 Never Married 2 X Merried	2. WAS DECEDENT E FORCES? 1	VER IN U.S. A	RMED	13. WAS	DECENDENT OF	HISPANIC O	RIGIN? (Specify	Yes or No-	14. RACE Black	- American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR		PARI		YES 2 NO		or to though with	,	Specifi	y:
	15. DECEDENT'S EDUCAT	lan. n	ECEDENTIA :	I CONTRACTOR	ATION!		441		Whi	te	
COMPLETED	(Specify only highest grade cor	mpleted)	- 0	ECEDENT'S U Give kind of wo le. Do NOT use	rk done during	ATION most of working		16b. KIND OF	BUSINESS/IN	IDUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)						т.			
MC	17. FATHER'S NAME (First, Middle, Last)	J H	lairdre	esser	40 5/07-	D'0 MATT		uty			
	Samuel	Fulto	n				ela.	First, Middle, Mai	den Sumame) Llo		
BE	190. INFORMANT'S NAME (Type/Print)		Ob Man mic -	DODESO (C					, –		
2	Frank A. Baker Jr		1			eet end Number or			Town, State, Z	(ip Code)	
	20a. METHOD OF DISPOSITION	205 21 5					Lloyd				
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	I from State		p. PLACE AND DATE OF DISPOSITION (Name of getery, crematory or other place) DPTINGNILL Memory Gai				DATE 20c.	LOCATION -		vn, State
	21. SIGNATURE OF FUMERAL SHOWE LICEN	SEE /	Spil	ringnill Memory Garde					Hebro	n, MD	
	1/1 1/1 .	Holloway Funeral Home									
	501 Snow Hill Rd Salisbury MD 21801										
	23. PART i. Enter the diseases, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between										
	IMMEDIATE CAUSE (Fine)										Onset and De
	disease or condition									10 mes	
	DUE TO (OR AS A CONSEQUENCE OF):										
Z											
임	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
8	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	that initiated events	DUE TO (OF	AS A CONSE	EQUENCE OF):							
H	resulting in death) LAST										
0	PART II. Other significant conditions of	contributing to de	ath hut not	resulting in	the under	vino cours ciu	on in Do-	1 84- 45-	AN AUG-200		
MEDICAL CERTIFICATION	g	THE PERSON NAMED IN CO.		.veuidig III	e unuen	ynig cause giv	TIET IN NO	PER	AN AUTOPSY FORMED?		WERE AUTOPSY FINDIN
								1 - YES	2 200		COMPLETION OF CAUS OF DEATH?
Σ	DID TODA CCO LICE CO.					-					1 YES 2 NO
AN	DID TOBACCO USE CONTRIE	SUIE TO CAUS		7.75			rtain [
PHYSICIAN		OSPITAL:			THER:						
ΥS		☐ Inpatient 2 ☐ Ef		3 🗆 DOA 4	☐ Nursing I	tome 5) Resid					
	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJ (Month, Day,		26b. TIME	RY	INJURY AT WORK?	_	. DESCRIBE HO	W INJURY OC	CCURED	
B⊀	2 Accident Investigation					YES 2 1	NO				
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF IN- building, etc.	IJURY — At h. (Specify)	ome, farm, atr	eet, factory, o	ffice	28f.	LOCATION (Str. City or Town, St		er or Rural Ro	oute Number,
ETE											
7	29a. CERTIFIER (Check only	N: To the best of my	knowledge, d	leath occurred	at the time,	late end place, er	nd due to Ih	e cause(s) end	menner as st	nted,	
2	(Check only one) 2 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner se stated.										
0 1											Month, Day, Year)
COMPL	296. SIGNATURE AND TITLE OF CERTIFIER	/				29c. LICENS			LTU. DA	· C SIGHED (month, way, rear)
띪		£ ,.	n.o.	,		0:	300	9		Sent.	21 100 -
띪	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE O	OF OEATH (ITE	EM 27) (Type P	rint)						21, 1995
띪	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE O	OF OEATH (ITE	EM 27) (Type P	rint)						
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	COMPLETEO CAUSE O	OF OEATH (ITE	EM 27) (Type, P	rint)						, MD
띪	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	COMPLETEO CAUSE O	OF OEATH (ITE	EM 27) (Type, P	rine)						



BALTIMORE, MARYLAND 21215-0020

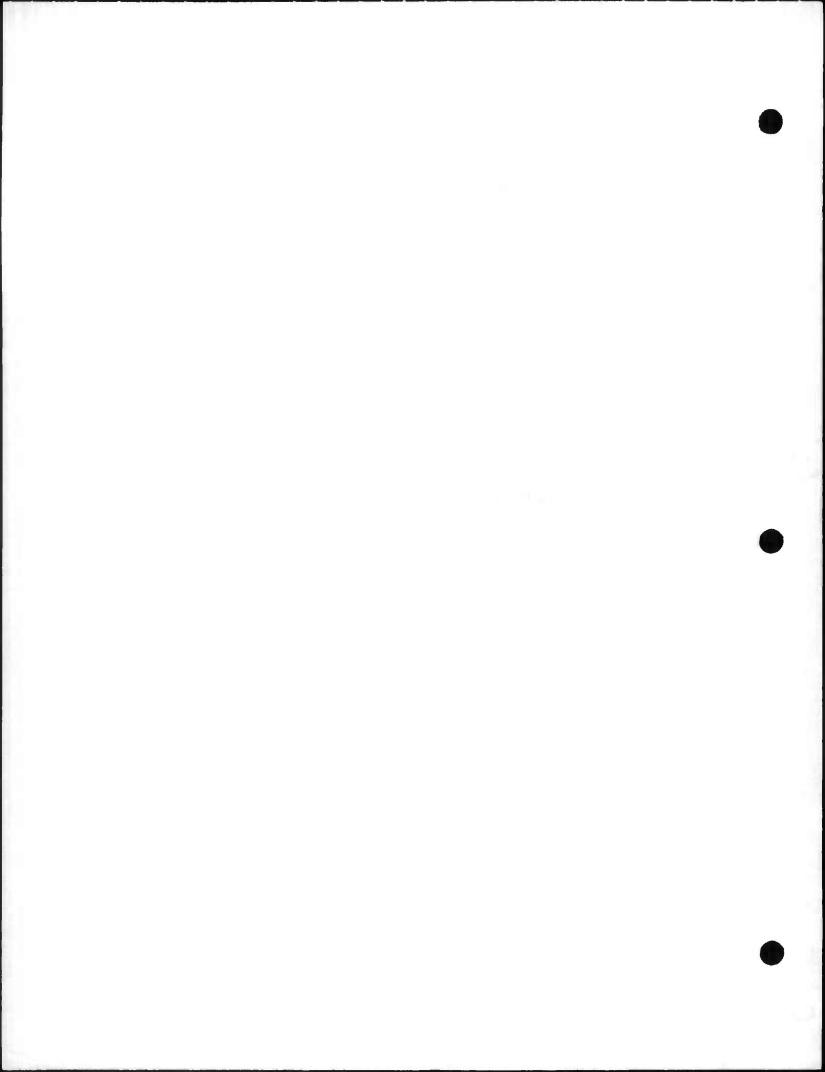
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) ROBERT	RUSSELL	Rei	Hook	<i>a</i>	MON1	E OF DEATH		YEAR 95	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 213-22-8490			IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH th, Day, Year) ember 27.	8	. BIRTHI Country	PLACE (State or Foreign	
OR	9a. FACILITY NAME (If not institution, give a PENINSULA REGIONAL)	-		SALISI	R LOCATION OF D			9c. COUNTY OF DEATH WICOMICO			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE Maryland Wice	comico		TOWN OR LOCAT						10d. INSIDE CITY LIMITS?	
FUNERAL C	10. STREET AND NUMBER 1013 Heron Ct.	Jointeo			21801				N OF W	1 YES 2 X NO	
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	If yes, spi	ENDENT OF HISPA celfy Cuban, Mexic 2X NO Speci	an, Puerto		Yes or No— 14. RACE — American Indian, Black, White, stc. Specify:			
COMPLETED	15. DECEDENT'S EDU (Specily only highest grade Elementary/Secondary (0-12)	CATION	16a DECEDENT'S III	rk done during mo: retired.)	N st of working		E Food se	INESS/INDUS		ce	
BE COM	17. FATHER'S NAME (First, Middle, Last) Alton Potts Britt	tingham Sr.			Alice		Middle, Maiden S ryn Der				
10	190. INFORMANT'S NAME (Type/Print) Melva Ann Britt:	ingham			nd Number or Rural Ct., Sal						
	20e. METNOD OF DISPOSITION 1 IX Burisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Donation 5 Under (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) Wicomico Memorial Park 22 NAME AND ADDRESS OF SACULTY.										
	Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801										
Z	IMMEDIATE CAUSE (Finel disease or condition resulting in desth) DUE TO (DR AS A CONSEQUENCE OF):									Approximate Interval Batween Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in desth) LAST										
PHYSICIAN: MEDICAL	PART II. Other aignificant condition Renal Failur Prevnonia		of not reaulting in	the underlying	cause given in	Part I.	24a. WAS AN A PERFORI 1 YES 2	MED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
SIAN:	DID TOBACCO USE CONTR	2	F DEATH YES		UNCERTAI	N 🔲					
1XSI	1 TYES 2 NO 27. MANNER DE DEATN	HOSPITAL: 114 Inpatient 2 ER/Outpe			5 Residence		or (Specify)				
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Morith, Day, Year)	INJUR	TY WO		200. DE	SCHIBE NOW IN	JUHY OCCUP	TED		
	3 Suicide 6 Could not be 4 Homicide determined	26e, PLACE OF INJURY building, atc. (Special	— At home, farm, stre	et, factory, office			CATION (Street er or Town, Stete)	nd Number or	Rural Ro	ute Number,	
COMPLETED		CIAN: To the best of my knowle R: On the beele of examination								end manner ee stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	7 :	n.o.		29c. LICENSE NUI					Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	D COMPLETED CAUSE OF OEA	TH (ITEM 27) (Type, P)	rint)	030					pt., 1995	
2	James E.	Martin n	1.0. 11	45 E	Carr	11.	Jr., -	5-1:5.	50.	7, MD.	
IA	SEP 2 0 1995	122. REGISTRAR'S SIONA	dall								

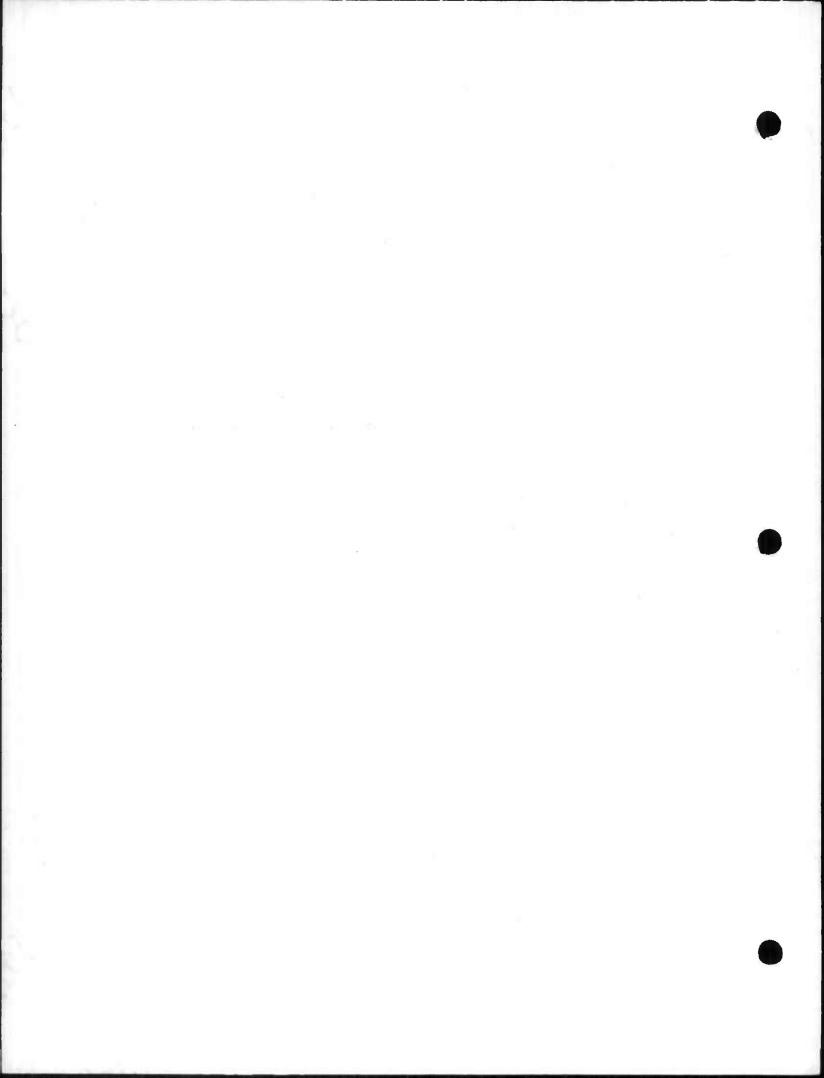


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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF STAT	MARYLAND / DE	PARTMENT OF H	EALTH AND M	ENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest)			T-	2. DATE OF DEATH		3. TIME OF DEATN			
	VADA RIT	P.A.	BRADS	HAW	MONTH DAY	1 9 9 5	4:55 A M			
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birti			7. DATE OF BIRTH		PLACE (State or Foreign			
	578-12-8383 1 M 2 X	76 Y	RS. MONTHS DAYS	HOURS MIN.	oril 20, 1919	Vir	ginia			
DIRECTOR	Weslevan Health Care Co	enter		ton	1.5		oline			
JEC	10s. STATE 10b. COUNTY		c. CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY			
	Maryland Caroline		Denton				1 YES 2 NO			
FUNERAL	10e. STREET AND NUMBER			ZIP CODE	10	g. CITIZEN OF Y	VHAT COUNTRY?			
崱	10668 Knife Box Road			21629		U.S.A.				
5	11. MARITAL STATUS 12. WAS DECE FORCES?	DENT EVER IN U.S. ARMED		ENDENT OF NISPANIC	ORIGIN? (Specify Yee or the Puerto Ricen, etc.)	No- 14. RACE Black	American Indian, t, White, etc.			
B	3 Widowed 4 Divorced	E WAR OR DATES	1 TYES			Speci	fyr			
	15. DECEDENT'S EDUCATION	16a, DECEDI	I ENT'S USUAL OCCUPATIO	N	16b. KIND OF BUSINE		asian			
Ē	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 o	(Give ki	nd of work done during mos NOT use retired.)	st of working	TOOL KIND OF BOOME	JOHNOUSTRI	40.00			
립	7	Purch	nasing Cont	rol Agent	Retai	1 Store				
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTHER'S NAME	(First, Middle, Meiden Surn	name)				
ш	James Alexand	ler Smith		Melvir	na Hottinge	er	1			
0 B	19a. INFORMANT'S NAME (Type/Print)	19b. MA	AILING ADDRESS (Street or	nd Number or Rural Ro	ute Number, City or Town, St	tete, Zip Code)				
-	Patricia A. Griffie	277	782 Burrsvi	11e Road,	Denton, Ma	aryland	21629			
	20e. METHOD OF DISPOSITION t ☑️Burial 2 ☐ Cremetion 3 ☐ Removal from State	20b. PLACE AND I	DATE OF DISPOSITION (Nat ry or other plece)	me of	DATE 20c. LOCATI	ION — City or To	wn, State			
	4 Donation 5. Other (Specify)	Denton	Cemetery	D ADDRESS OF FACE	10/3 Denta	on, Mar	yland			
	Moore Funeral Home, P.A.									
_	1 Transport	1180NC	PO D	rawer B.	Denton, Mai	rvland	21629			
	23. PART I. Enter the diseases, or complications ahock, or heart fature. List only one	that caused the death.	Do not enter the mod	de of dying, auch	as cardiac or respirato	ory arreat,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death) A ctastatic Rectal Caremona 1045									
	resulting in death) a			Tal Ca	remouna		10y0			
		TO (OR AS A CONSEQUEN	ICE OF):							
Ó	Sequentially list conditions, if any, leading to immediate	TO (DR AS A CONSEDUEN	ICE OF):							
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury									
E	that initiated events	TO (OR AS A CONSEQUEN	ICE OF):							
CERTIFICATION	reaulting in death) LAST									
AL C	PART II. Other algnificant conditions contributing	to death but not resul	iting in the underlying	cause given in Pr	ert I. 24s. WAS AN AUT		WERE AUTOPSY FINDINGS			
S	O Rectal Fistule	i = Int	echin		PERFORMED		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
PHYSICIAN: MEDIC	(D) CVA	0			_ 10 163 201		OF DEATH? 1 YES 2 NO			
ž	(3) Hemiplesia	1			_					
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL			ACE OF DEATN (Check	conty one)					
YSI	1 YES 2 NO 1 Inpatient	2 ER/Outpetlent 3 D	OTHER:	5 🗆 Residence 8	Other (Specify)					
PH		OF INJURY h, Day, Year)	b. TIME OF 28c. INJURY WOI		ed. DESCRIBE NOW INJUI	RY OCCURED				
BY	2 Accident Investigation			ES 2 NO						
TED	3 Suicide 8 Could not be 4 Homicide determined	E OF INJURY — At home, I ng, etc. (Specify)	lerm, etreel, lectory, office	1	18f. LOCATION (Street and h City or Town, State)	Number or Rural F	loute Number,			
COMPLET	29e. CERTIFIER (Check only	t of my knowledge, death o	occurred at the time, date	end place, and due to	the cause(s) and manner	ee stated.				
NO.	one) 2 MEDICAL EXAMINER: On the beats) and manner as stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER		4.0	29c. LICENSE NUMB			(Month) Day, Year)			
38 C	(ATX X	Jah V	M)	D47	492 1	10/	3/95			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED	AUSE OF DEATH (ITEM 27)	(Type, Print)			1				
ŀ	JEFFREY DENTON P.O.	B0X 122	GOLDSBOR	0, MD 2	21636					
	31. DATE FILED (MONTH). DO MAN)	MAR'S SIGNATURE	2.				4 4			
	401 2 00 0									



er death. Page 6 may be retained by the hospital	the funeral director, page 5 should be detached for val.	il examiner must be notified at once.	
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING	TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after deat	IMPORTANT: If Item 28 is m	

							9	5 3	1229	
	FOR STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGI REG.				
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	4	3.	TIME OF DEATH	
	Marie	Р.							1:05 A _M	
			444		IF UNDER 24 HRS. HOURS MIN.	(Month, Day, Yea	r)	Country)		
				b. CITY, TOWN O	R LOCATION OF DE					
OR		al of Easton		East	on		Т	albo	t	
ECT			10c. CITY, 1	TOWN OR LOCAT	ION			10	Dd. INSIDE CITY	
PIB	Maryland Doro	hester			Hurl	ock			LIMITS?	
3AL	10e. STREET AND NUMBER			101		13				
NE			OMED	12 WAS DEC						
	1 Never Merried 2 Merried	FORCES? 1 YES 2 V	NO	If yee, sp	ecity Cuben, Mexico	n, Puerto Ricen, atc.				
	••								White	
E	(Specify only highest grade	completed) ((ECEDENT'S US Give kind of wor b. Do NOT use i	SUAL OCCUPATION It done during mover tired.)	ON st of working					
PLE	Elementary/Secondary (0-12)		ocia1	Worke	er	Dorch	ester 1 Ser	Dep	t. of s	
	17. FATHER'S NAME (First, Middle, Last)	Roland S. Po	ole			ME (First, Middle, Ma				
	19e. INFORMANT'S NAME (Type/Print)									
F										
	1 XBuriel 2 Cremation 3 Rem	ovel from State	rompton, or otho	s place!		1				
			y-was	OO MANE AS	ID ADDRESS OF EA	CILITY				
	Muhil 7. Eskew PO Bx 43, Federalsburg, MD 21632									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.									
	IMMEDIATE CAUSE (Final disease or condition	MARCINE	CVA					1	Onaet and Death	
	reaulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
z										
ATIO	if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF):							
FIC	CAUSE (Disease or Injury	c. DUE TO (OR AS A CONS	EOUENCE OF):							
H	resulting in deeth) LAST	d								
2	PART II. Other significant condition	is contributing to death but not	reaulting in	the underlyin	g cauee given in	Part I. 24a. WA	S AN AUTOPSY	24b. W	/ERE AUTOPSY FINDINGS	
CA	ASCVD, C	DEOPOLOSES	22		Di 161	PE 1 7	RECORMED?	0	MAILABLE PRIOR TO COMPLETION DF CAUSE	
MED									YES 2 NO	
	DID TOBACCO USE CONT				UNCERTAI	N 🗆				
ICIA	EXAMINER?	HOSPITAL:		OTHER:						
HYS	27. MANGIER OF DEATH	28e. DATE OF INJURY	28b. TIME	OF 28c. IN.	JURY AT			CCURED		
	Natural 5 Pending Investigation	(Month, Day, Year)	INJU							
0	3 Suicide # Could not be determined	28e. PLACE OF INJURY — At I building, etc. (Specify)	home, ferm, str	reet, fectory, otilo	0			er or Rural Rou	ite Number,	
LET	200. CERTIFIER CERTIFYING PHYS	ICIAN: To the best of my knowledge	death occurred	at the time, date	end place, and due	e to the cause(e) en	d manner ea str	sted.		
JMC	(Cour only								and manner as stated.	
	250. SIGNATURE AND TITLE OF CENTERS	6 P- 400			_	IMBER	29d. DA	TE IGNEO (A	Month, Day, Year)	
BOWGLE 1. SECOLAL SECURITY NUMBERS 2. SECURITY NUMBERS 2. SECURITY NUMBERS 3. SECURITY NU			191							

29c. LICENSE NUMBER PLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

29d, DATE SIGNED (Month, Day, Year)

MD 21601 Kevin Keefe, M.D.,

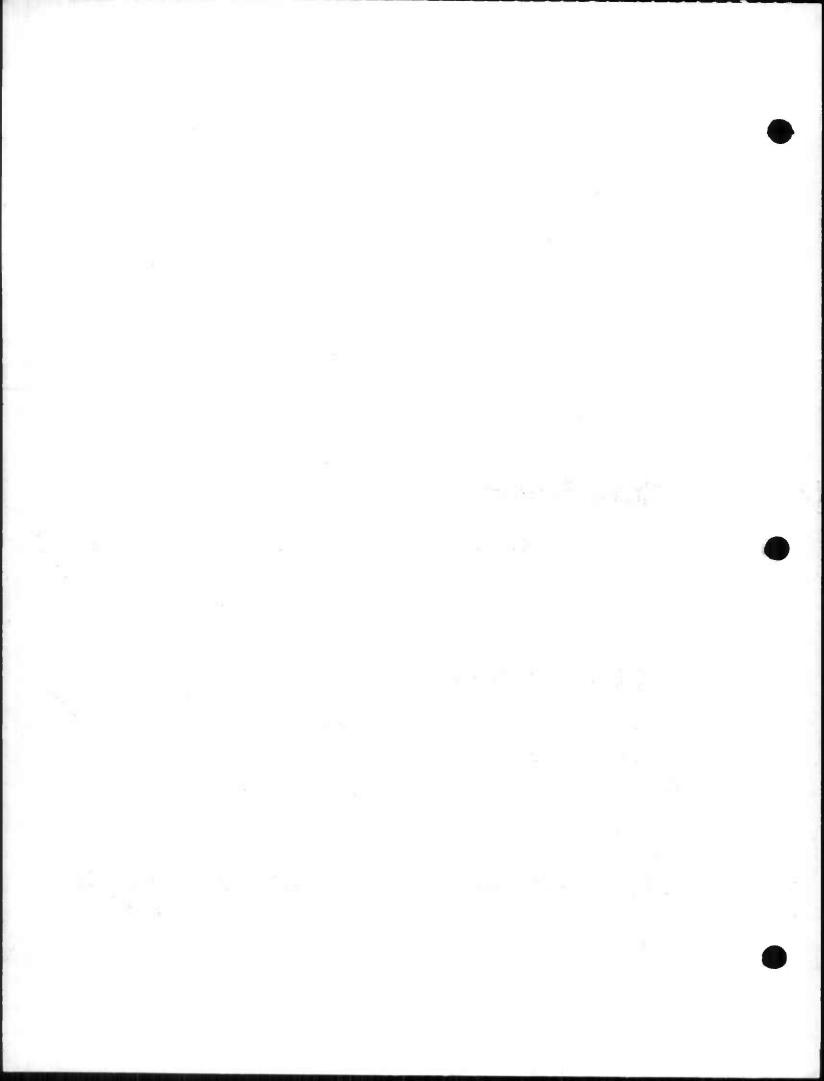
31. OATE FILEO (Month, Day, Year)

OCT - 2 '95 606 Dutchman's Lane, Easton,

2

32. REGISTRAR'S SIGNATURE

in waydson-Randele



DIRECTOR

FUNERAL

ВУ

ETED

COMPL

5

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

ш 8

9

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111

32 ANGISTANT'S SIGNATURE AND LOCAL

MONE MCKIA

31. DATE FILED (Month 2 00) 95

sician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p		
**O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed will are 74 hours after death. Page 6 may be retained by the hospital or attending physician	the bun		
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OR AT	DIRECT	hours a	item 2
SPITAL	NERAL	thin 72	NT: If
THE H	THE FU	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	2	2	Σ

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR BENNETT, 1995 THOMAS SEPT. 1500 РМ Α. Jr. 7. DATE OF BIRTH (Morth, Day, Year) 05/23/68 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS HOURS 27 1 X M 2 T F 219-02-1840 Maryland 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PENINSULA REGIONAL HOSPITAL SALISBURY WICOMICO RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Caroline Maryland Federalsburg 1 TYES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 122 West Central Avenue 21632 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxicen, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Merried Specify: White 1 YES 2 XNO Specify: 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Frozen Food Storage Warehouse Worker 12 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Thomas Arthur Bennett, Sr. Joyce M. Hulliger 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 21632 122 West Central Ave., Federalsburg, Joyce M. Bennett 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 20e, METHOD OF DISPOSITION

1 St Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Crest Cemetery 9/ 9/30 Federalsburg, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Framptom-Hawkins-Eskow Funeral Home Muchan Eskow PO Bx 43, Federalsburg, MD 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition u reaulting in death) DUE TO (OR ASIA CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO DE DEATH? TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) XXYES 2 NO 1 ☐ Inpatient 2XIXR/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 1 YES 2 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending (20 HB 2 Accident 28e. PLACE OF INJURY - At home, farm, street, fect rei Route Number, Feelewys bus 281. LOCATION (Stree 3 Suicide 6 Could not be determined work 29a. CERTIFIER
Thank only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner es stated. 2 X MEDICAL EXAMINER: On the basis of example of example of the basis of example of the basis of ation end/or investigation, in my opinion, dasth occured at the fima, date end placa, end due to the ceuse(s) and manner as stated. 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 200 O.C.M.E SEPT, 28, 1995

Penn Street, Baltimore, Maryland 21201

		1 - FOR STATE OF MARYLAND / DEPARTMENT OF MARY	PEPARTMENT OF		MENTAL HYGIEN	E	
		t. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
			_OODSWORT	TH	Sept. 28,	1995 YEAR	2:35 PM
2		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last b) 1 □ M 2 ► 89	YRS. F UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) Feb. 26,	8. BIRTI- Count 1906 Mar	
pinous	œ	9a. FACILITY NAME (If not institution, give street and number)		VN OR LOCATION OF D		9c. COUNTY OF D	
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permit. Pages	DIRE	Maryland Wicomico	10c. CITY, TOWN OR LO				10d. INSIDE OTTY
ermit.	AL C	100. STREET AND NUMBER	Salisb	101. ZIP CODE		10g. CITIZEN OF V	1 YES 2 NO
	IER/	506 Douglas Road		21801		U.S	
AND 21215-0020 he hospital or attending physician. detached for use as the bunal-transit once.	BY FUNER	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	If yes	DECENDENT OF HISPA , specify Cubar, Mexic YES 2 NO Speci		or No- 14. RACE	
215 attend se as	ED	15. DECEDENT'S EDUCATION 18a. DECE (Specify only highest grade completed) (Give	DENT'S USUAL OCCUP	ATION	16b. KIND OF BUS	SINESS/INDUSTRY	
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AND the hospital detached for	COMPL	8 H	<u>ousewife</u>		Own I		
ام ه م ا	_	John Wesley Ford			AME (First, Middle, Maiden Stina Cati	0.00	
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ORE 6 may ector, pag must b		1 Burial 2 Cremation 3 Removal from State cemetery, crema	D DATE OF DISPOSITION story or other plece)		1	CATION — City or To	
Page dire		4 Donetion 8 Other (Specify) St. A 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	ndrews E	DISCODAL E AND ADDRESS OF FA	10/2 Pr	Anne,	Md.
ALTIN death. Pag tuneral di J. examiner		►			eral Home		
BALT nours after death. of in by the funera or removal.		23. PAPTA. Enter the diseases, or complications that caused the death	h. Do not enter the	incess A mode of dylng, aud	nne Md.	21853	Approximate
ith hour letely filled in emation, or n		shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death)	6000+	61/20			Onset and Death
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를 들을 들	AL.	PART II. Other algnificent conditions contributing to death but not rea	ulting in the underl	ying cause given in	Part I. 24s. WAS AN PERFOR		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
RECORD requires that the seen signed by th of Health and In	EDIC				1 YES 2		COMPLETION OF CAUSE OF DEATH?
shoy	2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	VEC II NO	□ HNCEDTAL	N. [7]		1 Nes 2 No
The law tee has b ate Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE	OF DEATH (Check only o		N LJ		
VIIAN: The State I he State or item	YSIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3	DOA 4 Nursing h	iome 5 Residence	8 Other (Specify)		
NG PHYSIC fler this ce eath with th	ВУ РН	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 2 Accident Investigation	INJURY	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW IF	NJURY OCCURED	
TOR: A after da after da se is	8	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home building, etc. (Specify)	, term, street, tectory, o	office	28f. LOCATION (Street a City or Town, State)	nd Number or Rural R	louis Number,
4 4 2 E	COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axaminstion and/or inventoring the basis of axaminstion and/or inventoring the basis of axaminstion and/or inventoring the basis of axaminstion and/or inventoring the basis of axaminstion and/or inventoring the basis of axaminstion and/or inventoring the basis of axaminstical axaminst					and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE C	296. SIGNATURE SKID TITLE OF CENTIFIER		29c. LICENSE NU		29d. DATE SIGNED	(Month, Day, Year)
222	5	30. NAME AND ADDRESS OF PERSON WILL COMPLETED CAUSE OF DEATH (ITEM 2	(Type, Print)	DFOR		9/29	777
		31. DATE FILED (MONTH, Day, Year) 32. REGISTRAB'S SIGNATURE	100 Tow	mer st.	Salisbury	MD21	P0 /
		OCT 0 2 1995 John a hudson-hardell					

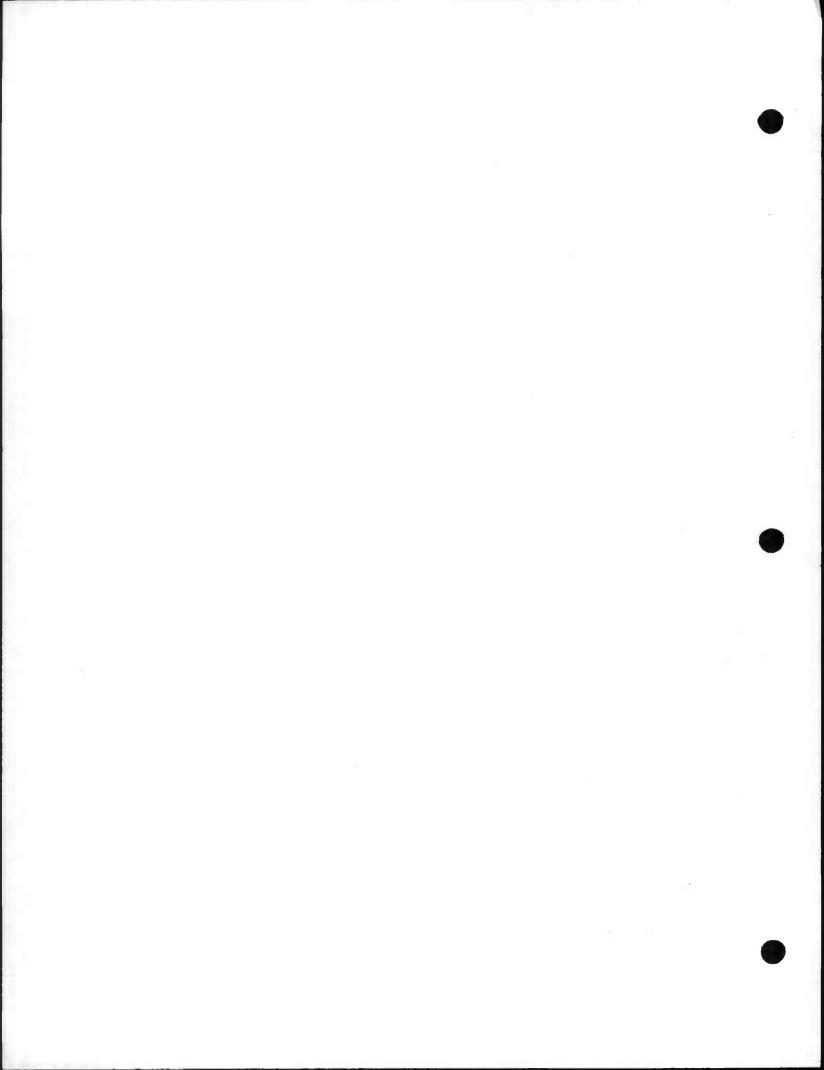
DIVISION

		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT OF	HEALTH AND	MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last) Charles	Lewis BURCK				october 2,	19 95 YEAR	3. TIME OF DEATH 2:40 PM		
2		4. SOCIAL SECURITY NUMBER 214-10-1799	1XXM 2 □ F 8	In yrs. lest birthde	MONTHS DAY	7	July 28,1	910 Ma	THPLACE (State or Foreign ry)land		
2, 3 should	10R	Frederick Healt		•		n or Location of C erick	DEATH	9c. COUNTY OF Freder			
permit. Pages 1,	DIRECTO	10a. STATE 10b. COUNT	derick		ederick				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
is.	ERAL	100. STREET AND NUMBER 800 Motter Ave	nue			10f. ZIP CODE 21701		U.S.A	WHAT COUNTRY?		
5-0020 Inding physician. Is the burial-transit	BY FUNER	11. MARITAL STATUS 1. Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES GIVE WAS ON DO NOV. 12,1942-00	U.S. ARMED 2 NO ATES 28,19	If yes,		ANIC ORIGIN? (Specify Yesten, Puerto Rican, atc.)	Ble	CE — American Indian, ck, White, atc. white		
2121 al or afte for use a	IPLETED	15. DECEDENT'S EDI (Specify only highest gred Elementary/Secondary (0-12)		16a. DECEDENT (Give kind o	'S USUAL OCCUP! If work done during use retired.) UPERVIS	most of working		ic Suppl			
YLA by the	d at once.	17. FATHER'S NAME (First, Middle, Last) William Al	exander BURC	ĸ		16. MOTHER'S N Nell	AME (First, Middle, Meiden ie	Sumame) BENDE	R		
E, MAR y be retained age 5 should	TO B	Mrs. Airy V. Kee	ney	19b. MAILH 704	North M	et end Number or Rurel arket Str	eet, Frede	rick, Md	. 21701		
6 may	must	26g. METHOD OF DISPOSITION 1-1/3 Burlel 2 Cremetion 3 Reg 4 Donation 5 Other (Specify)	novel from State 20b	PLACE AND DAT		cy, Oct. 5,	1995 Fr		Maryland		
AL death.	examiner	21. SIGNATURE OF FUNEBAL SERVICE L	CENSEE	M00255	22. NAME Kee 106	ney and B East Chu	asford P.A	. Funera	1 Home , Md. 21701		
writhin 54	event, the medical	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. Liet only one cause on asch lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
death certificate be executed attending physician and con	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST	b. DUE TO (OR AS A c. DUE TO (OR AS A d.								
80 6	shows any injury. HEDICAL CE	PART II. Other algoliticant condition	na contributing to death be	. ^	in the underly	ring ceuse given in	Part I. 24a. WAS AN PERFOI	RMED?	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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IG PHYSICIAN ter this certific	marked, or BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 ER/Outp. 28e. DATE OF INJURY (Month, Day, Year)	28b. T	ME OF 28c.	ome 5 Residence INJURY AT WORK? YES 2 NO	8 Other (Specify) 28d. DE\$CRIBE HOW	INJURY OCCURED			
DR ATTENDIN DIRECTOR: AN	item 28 is n	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm	, street, tectory, o	Hice	28t. LOCATION (Street City or Town, State)	end Number or Rural)	Ploute Number,		
Z Z Z	2 = 5		ICIAN: To the best of my knowl R: On the basis of exemination						(e) end manner ea stated.		
THE H	E H	296. SIGNATURE AND TITLE OF CERTIFIE	S. Von	d.,,		29c. LICENSE NU D 1819			3, 1995		
		30. NAME AND ADDRESS OF PERSON WI	O COMBI ETED CALLES OF DE	THE STEAM OF ST	010						

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

Dr. Arthur G. Manalo MD 187 Thomas Johnson Drive, Frederick, Maryland 21702

32. REGISTRAN'S SIGNATURE
Pavelion-Randall 31. DATE FILED (Month, Day, Year)
OCT 0 4 1995



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

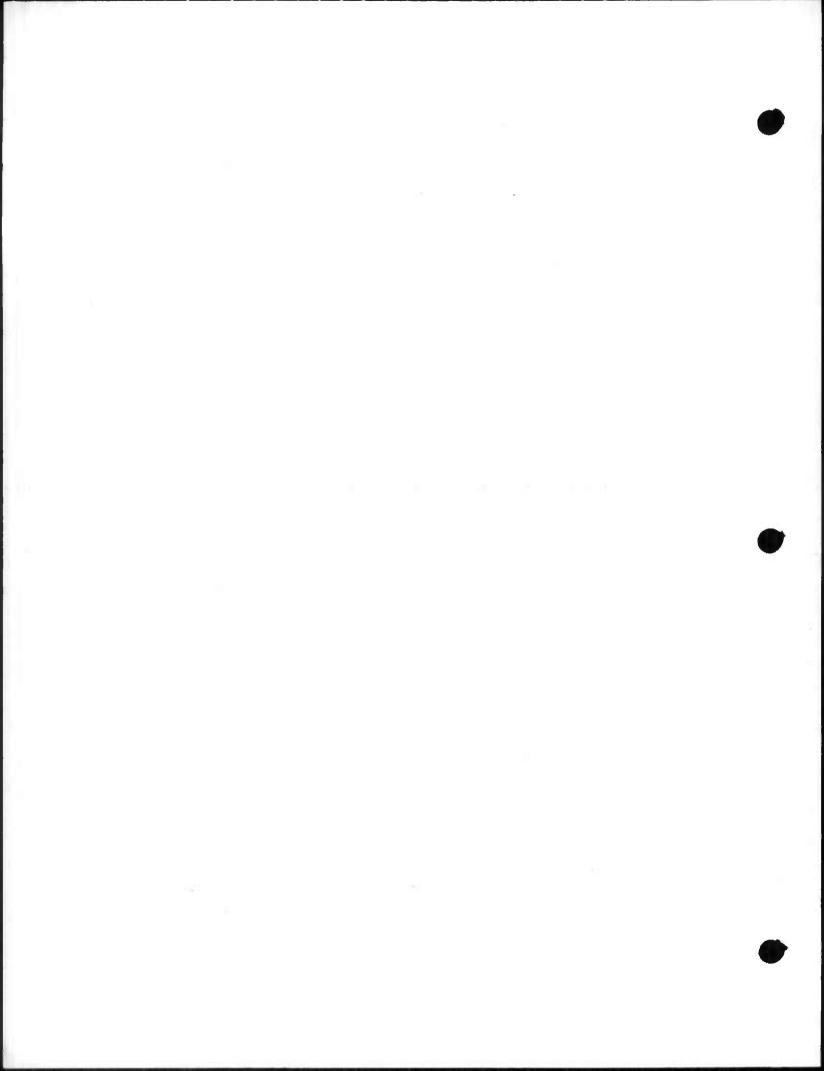
		1. DECEDENT'S NAME (First, Middle John	_	bras	hear	~	JI DLA	(2. DATE OF DEATH	AY	YEAR (95 (OT30 M	
		4. SOCIAL SECURITY HUMBER 212-26-6695	5. SEX 8. AG	E (In yrs. les	t birthday)	F UNDER 1 YE		MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLAC	CE (State or Foreign	
2, 3 should	OR	96. FACILITY NAME (# not institution Shady Grove	n, give street and number)				WN OR LOCAT	ION OF DEA	July 6,1	9c. COUNT	Mar TY OF DEATH		
OZO physician. burial-transit permit. Pages 1, 2	DIRECTO		COUNTY		10c. CITY, TOWN OR LOCATION							INSIDE CITY	
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attending physician se as the burial-train	B	11. MARITAL STATUS 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 N		If yes	DECENDENT 6, specify Cube	en, Mexican,	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	Black, Wh	Mhite	
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Spital Spital	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)		Custodial Worker			County	y Scł	1001	System		
		17. FATHER'S NAME (First, Middle, L				18. MOT		E (First, Middle, Maiden					
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e 6 may rector, pa		20e. METHOD OF DISPOSITION POBuriel 2 Cremetion 3 (4 Donation 6 Other (Specific	C Removal from State	emetery crei	MDDATEOFI matory or other asant	nlacel		neter	1		ty or Town, S		
death. P		Pleasant Hill Cemetery 10/3 Monrovia, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dlin L Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland											
filled in by the on, or removal.		23. PART i. Enter the disease ahock, or heert fi	ea, or complications that caus allure. List onlylons cause on	ed the da	eth. Do not	anter tha	mode of dy	/ing, auch	ROAD DO	masci ratory arre	it,	Approximate interval Between Onset and Death	
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e be executed sician and con rior to burial, traumatic ex	TION	if any, laading to immediate OUE TO (OR AS A CONSEQUENCE OF):										MONTHS	
th certificat ending phy I Hygiene p	CERTIFICATION	CAUSE (Disease or injury that initiated events reaulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF): d.										MONTHS	
the d We		PART II. Other aignificant con	nditiona contributing to death	but not re	esulting in t	tha underl	ying cause	givan in Pa	ert i. 24s. WAS AH PERFOR			E AUTOPSY FINDINGS	
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SICIAN: The law certificate has the the State Depth the State Depth or Item 23	PHYSICIAN:	EXAMINER?	HOSPITAL:		_ 0	THER:		esidence 6	Other (Specify)	·	<u>.</u>		
도 음 등 이	ву рну	27. MANNER OF DEATH 1 Ketural 5 Pendin 2 Accident Investig			26b. TIME O	₽F 28c.	IHJURY AT WORK?	2	8d. DESCRIBE HOW IN	IJURY OCCU	RED		
OR ATTENDING P. DIRECTOR: After the hours after death vitem 28 is mark		3 Suicide 6 Could a determine		RY — At hor	ne, farm, stre	et, factory, o	office	2	6t. LOCATION (Street e. City or Town, Stete)	nd Number of	Rural Route	Number,	
7 40 -	COMPLETED		PHYSICIAH: To the best of my kno XAMIHER: On the beele of examinat									menner se atated.	
TO THE HOSPITY TO THE FUNERA De filed within 7. IMPORTANT: 1	TO BE	296. SIGNATURE AND TITLE OF CE	Zenn Dand)a-	MAC		29c. LIC	EHSE HUMBI	2.5	29d. DATE :	signed (Mon	th. Day, Year)	
		Glenn Sandle	MD 20529	8 Bo	(Card	Farm	P)	#207	german	bra.	MO	20874	
		31. DATE FILED (MONIN, Day Year) OCT 04	1995 32. REGISTRAR'S SIG	HULLON-A	arlalli				J		À.		

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ORDS, P.O. BOX 68760	is that the death certificate be execute

STATE OF	MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	C	ERTIFICATE	OF DEAT	TH		REG NO

		_	FOR STATE REGISTRAR	STATE OF MA	RYLAND	DEPAR	TMENT	OF H	EALTH AND		GIENE		
		1	1. DECEDENT'S NAME (First, Middle, Las	10						2. DATE OF DI		YEAR	3. TIME OF DEATH
			Emma	Jean Cole						Septem			4:11 p
P			4. SOCIAL SECURITY NUMBER 380-22-1476	1 □ M 2\\ F	AGE (In yrs. I	est birthday) YRS.	IF UNDER MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BII (Month, Day, Aug.	Year)	Countr	PLACE (State or Foreign Chigan
2, 3 shor	2	20	90. FACILITY NAME (If not institution, given Residence: 314	e street and number) Poplar Poin	t Road	1	9b. CITY,		erryvill		9c. COU	Ce	cil
020 physician. burial-transit permit. Pages 1, 2, 3 should		DINEC	10e. STATE 10b. COU	Cecil	10c. CITY, TOWN OR LOCATION Perryville							10d. INSIDE CITY LIMITS? 1 YES 2 NO	
sit permit	I VO	INAL	314 Poplar Point	int Road				-	. ZIP CODE	903	10g. CIT		HAT COUNTRY?
1215-0020 r attending physician. use as the burial-tran	CHACOAL	- 11	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENCE FORCES? **	YER IN U.S. A LYES 2 OR DATES	NO	11	yes, spe	ENDENT OF HISPAI ecity Cuben, Mexica 2 X NO Specifi	NIC ORIGIN? (Spen, Puerto Rican,	ecify Yes or No— etc.)	Black	- American Indien, White, etc.
	ETEN BV		3 Widowed 4 Divorced 15. DECEDENT'S E (Specify only highest gri	1944 -	194	ECEDENT'S	USUAL OC	CUPATIO	DN .		OF BUSINESS/INC	Speci	White
21 for u		IL CE	Elementary/Secondary (0-12)	College (1-4 or 5+) Two Years	- A	Ne. Do NOT u	memal		st of working				
2 3 3	ed at once.		17. FATHER'S NAME (First, Middle, Lest) Louis	DeMers					16. MOTHER'S NA	ME (First, Middle, Emma Tu			
, MARYI be retained by ge 5 should be notified at	TO T		190. INFORMANT'S NAME (Type/Print) Vivian C. Wallac						int Road				and 21903
MORE, ge 6 may be irector, page	E CST		20e. METHOD OR DISPOSITION 1 Burial 2 Concernation 3 Re 4 Donation 5 Other (Specify)		20b. PLACE R. A.	remetory or of Ferr	of bisposi ther place) LS &	tion (Na Comp			20c. LOCATION — West Chest		ensylvania
BALTIMORE, ler death. Page 6 may be the funeral director, page	examiner	1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903										
within 24 npietely fille cremation,	event, the medical		23. PART I. Enter the diseases, o ahock, or heart failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. A S	on each lin	7	not enter	the mod	de of dying, auc	h aa cardiac o	r reapiratory ari	reat,	Approximate interval Between Onset and Death
RECORDS, P.O. BOX 68760 with wrequires that the death certificate be executed with we require that the death certificate be executed with the argined by the attending physician and complete pt. of Health and Mental Hygiene prior to burial, cret 3 shows any Injury, or other traumatic even	or other traumatic		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	R AS A CONSI								
	- A		PART II. Other algnificant conditi	ona contributing to de	eth but not	reaulting	In the un	derlying	j cause given in	1	WAS AN AUTOPSY PERFORMED? YES 2 NO	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
- se se c	Z3 sho		DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUS					UNCERTAI	V 🗆			1 YES 2 NO
上 年 書書	PHYSICIAN		EXAMINER?	HOSPITAL:		3 DOA	OTHER		5 N Reeldence	6 Other (Spec	://y)		
ON OF VI DING PHYSICIAN: After this certifica death with the St	marked, BY PH	- 46	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation		Year)		PRESE		RK? ES 2 NO		HOW INJURY OC		
ISIC TTEND TTEND TOR: A after d	ED G		3 Suicide 6 Could not b								or Rural R	oute Number,	
HOSPITAL OF FUNERAL DII WITHIN 72 hou	COMPLET		29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piace, end due to the cause(e) and manner se stated.										
TO THE HOSPITAL TO THE FUNERAL De filed within 72 i	TO BE		29b. SIGNATURE AND TITLE OF CHATTE	wham	m	10-		<u> 1</u>	D 35	179	29d, DAT	SIGNED	(Month, Day, Year)
			30. NAME AND ADDRESS OF PERSON V Wallace Bra 31. DATE FILED (Morith, Day, Year)	VHO COMPLETED CAUSE OF CAUSE OF COMPLETED CAUSE OF CAU	nsh	E/7) (Type,	Print) MK	E	mer.	Pept.	Union	Hos	- FIKto
			SEP 2 8 1995	Julia Davilson								,	DHMH-16 Rev 1/8



BALTIMORE, MARYLAND 21215-0020	mours after death. Page 5 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a nouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

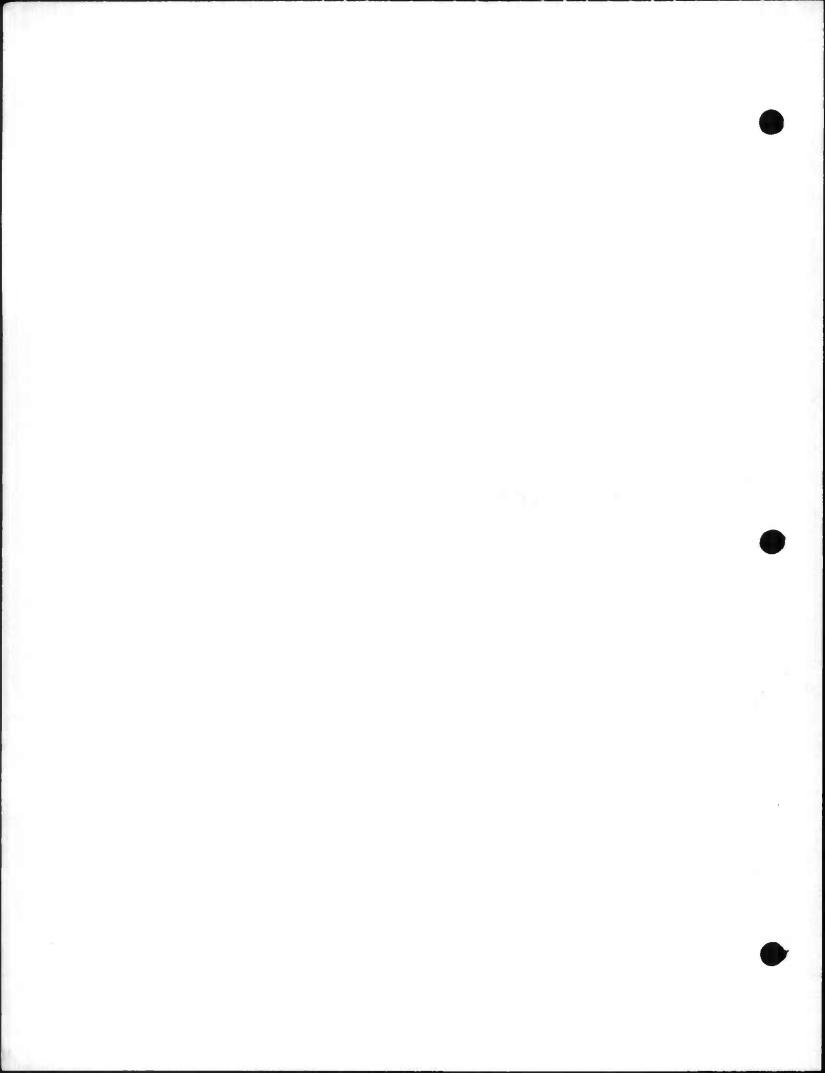
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR		CERTIFIC	ATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH		3. TIME OF DEATH		
	EILEEN COMP CAMPI	BELL				SEPT.	29 DAY	1995 YEAR	2130		
	100 01 10/0	6. AGE (In yrs. 78	lest birthday) IF	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B	IRTH		PLACE (State or Foreign Virginia		
Œ	99. FACILITY NAME (If not institution, give street Frederick Memoria	t and number)	91	Freder	OR LOCATION OF OR	c. COUNTY OF GEATH Frederick					
12	RESIDENCE OF DECEDENT										
2	100. STATE 10b. COUNTY		the CITY T	OWN OR LOCAT	TION						
DIRECTOR	Maryland Freder	rick		derick					10d. INSIDE CITY LIMITS? t 2 YES 2 NO		
FUNERAL	903 Pontiac Avenue	2		101	21701		10	WHAT COUNTRY?			
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 24 IF YES, GIVE WAR OR DATES	ARMEO	If yes, sp	AS OECENDENT OF HISPANIC ORIGIN? (Specific Cuban, Mexican, Puerto Rican, at YES 2 NO Specify:			Black, White, etc. Specify:			
ED	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION 16a.	DECEDENT'S US			16b. KIN	OF BUSINE	ESS/INDUSTRY	White		
COMPLETED		College (1-4 or 5+)	(Give kind of work life. Do NOT use no U.S. Go	ntired.)		N	one				
8	17. FATHER'S NAME (First, Middle, Last)			7 0 2111							
BE C	Harry Comp				18, MOTHER'S NA TRYTHOSA Pryphos	a Pris	cilla	George			
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	and Number or Rural F						
2	Mr. Thomas D. Camp	bell	903 Po	ntiac	Avenue,	Freder:	ick, 1	Marylan	d 21701		
	20e METHOD OF DISPOSITION t	I from State 20b. PLAC	CE AND DATE OF D	DISPOSITION (No	ame of	DATE		ION — City or To			
4 Donetton 5 Other (Specify) 10/2 Westernport, Maryl 22. NAME AND ADDRESS OF FACILITY											
	Take of S	hike of	7	ROBER	T E. DAI	LEY & S			HOMES, P.A. , MD 21701		
	23 PART I. Enter the diseases, or con-	plications that causes the	death. Do not	anter tha mo	da of dying, auci	as cardiac	or respirate	Dry arrest,	Approximata		
1	IMMEDIATE CAUSE (Final	t only one quise ogreach il	Ine.						Interval Between Onset and Death		
	disesse or condition	1-11	colle	1	- 124	1		1. 1	Onset and Death		
	resulting in death) s	DUE TO (OR AS A CON!	SEOUENCE OF):	eour	Chris	20001	exec	car de	ense 19ag		
z	disease or condition resulting in death) s. Attack Claratic Cardinary Ideas Iday Sequentially list conditions b.										
CERTIFICATION	Sequantisliy list conditions, if any, lasding to immediata cause. Enter UNDERLYING	DUE TO (OR AS A CONS	SEOUENCE OF):		· · · · · · · · · · · · · · · · · · ·						
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	SEQUENCE OF)								
ERT	resulting in death) LAST										
LC	PART II. Other significant conditions c	ontributing to death but no	ot resulting in t	hs underlying	cause given in	Part I 24a	WAS AN AUT	mesy Tab	WERE AUTOPSY FINDINGS		
DICAL	Bypass-woron					-1	PERFORME	0?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ш	Heston of	Colon la	enre.	, ,	Julia	1	YES 2	NO	OF DEATH?		
W :	- 1009 07	La Carrie	- Can			-			1 TES 2 NO		
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PL	ACE OF DEATH (Che	ock only one)					
Sic		OSPITAL:		THER: Nursing Hom	e 5 🗆 Residence	6 Other (Spe	icify)				
표	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 26c. INJ				RY OCCUREO			
ВУ	12 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1	rES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY — At building, etc. (Specify)	home, farm, stree	et, factory, offic	•	261. LOCATION City or Tox		Number or Rural F	loute Number,		
۳	298. CERTIFIER	No To the heat of an investment	4								
COMPLETED		N: To the best of my knowledge, On the basis of examination and/o) and manner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1001		1/2	29c. LICENSE NUM	BER	29	d. DATE SIGNED	(Month, Dgy, Year)		
10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE AS	ippies	4240	<u></u>	518	3 1	101	2/95		
	Ali J. Afrookteh,	M.D. 300 Wes	st 9th 9		Frederi	ck, Ma	rylan	d 21701			
	31. DATE FILED (Month, Day War) OCT 0 2 1995	32. REGISTRANG SIGNATURE	Realite								

DIVISION OF VITAL RECORDS.

FOR STATE REGISTRAR	STATE OF I			TMENT OF I		MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last) Dorot	hy E	dna	CRI	UM		2. DATE OF DEATH DAY September 2
4. SOCIAL SECURITY NUMBER 216-80-7946	5. SEX	6. AGE (In yrs. lest		IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 1,191

		Dorot	hy Edna	C	RUM		2. DATE OF DEATH September	DAY	3. TIME OF DEATH 95 9:05 am M		
pin		4. SOCIAL SECURITY NUMBER 216-80-7946	1 🗆 M 2 🔀 F	(In yrs. lest birthda) 78 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	June 1, 1	917	e. BIRTHPLACE (State or Foreign Country) Maryland		
1, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give some serior of the serior of				erick	EATH		rederick		
permit. Pages	DIRECTOR		ederick	10c. C	Frederi			75	10d. INSIDE CITY LIMITS? 1 YES 2 A NO		
. tis	FUNERAL	5740 Main's Lane			1	01. ZIP CODE 21704		10g. CITIZI	U.S.A.		
Z 15-UUZU attending physician. se as the burla-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	if yes, s	CENDENT OF HISPA pecify Cuban, Mexico S 2 X NO Specif	NIC ORIGIN? (Specify an, Puerto Rican, etc.) y:	Yee or No 1	14. RACE — American Indian, Black, White, etc. Specify: White		
spital or ed for u	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind o	's usual occupat of work done during in use retired.) emaker	ION nost of working	16b, KIND OF	BUSINESS/INDU	Home		
y be retained by sage 5 should be be notified at	BE CO	17. FATHER'S NAME (First, Middle, Last) Alton	J.	KIMMELL		Ruth	ME (First, Middle, Mei C .		GOODMAN		
	10	Mrs. Shirley A.	-	1304	2 Penn S	hop Road		iry, Ma	aryland 21771		
		20a METHOD OF DISPOSITION 1.8 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIK	M	petery, cremetory of		ery Oct 3	,1995 1		ck, Maryland		
death. e funera ii.		Lett him	w Kiberson) м00706	Kee 106 E	ney & Bas ast Churc	sford P.A ch St. Fr	ederick	. MD 21701		
or in the second of the second	ICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS)	A CONSEQUENCE	VÀ OF): NE NE NE NE NE NE NE NE NE N		Ailu		Approximate Interval Between Onset and Death Support		
Hy Hy	CERTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d.									
signed by Health and Ire	MEDICAL	PART II. Other algnificant condition	a contributing to death b	out not reaulting	in the underlying	ng cause given in	PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
law is be ept.	SICIAN:	DID TOBACCO USE CONTI 25. WAS CASE REFERRED DE MEDICAL			YES NO [N 🗆				
PHYSICIAN: The this certificate ha with the State Direct or litem	YSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outs			ne 5 🗆 Residence	8 Other (Specify)				
PH The Marie The Table 1	ву РНҮ	1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1 □	JURY AT ORK? YES 2 NO	26d. DESCRIBE HO	W INJURY OCCU	RED		
TTENDI CTOR: A affer de	a	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spe-	r — At home, ferm cify)	, street, fectory, offi	ee	28f. LOCATION (Stre City or Town, St		r Rural Route Number,		
HOSPITAL DR A FUNERAL DIREC WITHIN 72 hours	COMPLET		CIAN: To the best of my know						i. ceuse(s) end manner as stated.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	TO BE C	296. SIGNATURE AND HTLE OF CERTIFIED	SUT	ront	HE.	29c. LICENSE NUI D35183			ot 29, 1995		
		Ali J. Afrookteh	, M.B., 300	West Ni	nth Stre	et, Frede	erick, Ma	ryland	21701		
		31. DATE FILES (MONTH), DO 1847 1995 32. REGISTRAN'S SIGNATURE									



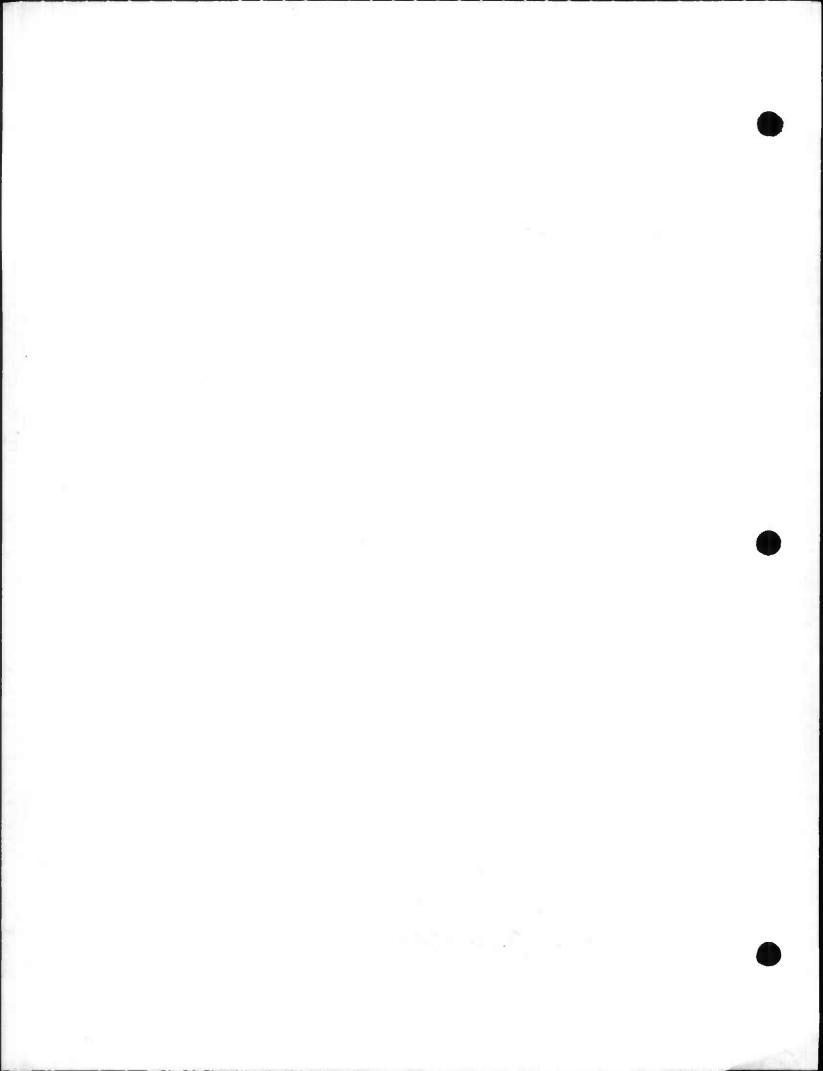
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he filed within 72 hours after death with the State Dent of Health and Mental Honiene more to hurial cremation or removal
Out the London-London Control and Control
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dent of Health and Mental Hyndens Hynde
TO THE MOSFINAL ON ALLENOWING PRINCIPANT: THE AW REQUIRES THAT DEPORT OF CHILDREN OF THE MOSFITAL ON ALLENDED PRESIDENT. THE MOSFITAL ON ALLENDER THE STATE THE CHILDREN AS PERSONAL DIRECTORS, After this certificate has been signed by the statements of physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after dark with the State has the Mostat
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dear of Health and Mental Horiene prior to burial cremation or remove!

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)		02.111110	AIL OI	DEATH	2. DATE OF DEATH		3. TIME OF DEATH		
	Mary Eliz	abeth Dave	nport			Sept. 26,	1995 YEAR	9:30 A M		
			yrs. lest birthday)	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	IL BIRT	HPLACE (State or Foreign		
	219-01-4731 1	□ M X X F 89	YRS.	HTHS DAYS	HOURS MIN.	Dec 6, 19		ryland		
œ	Glasgow Nursing H		91		ridge	EATH	9c. COUNTY OF Dorch			
5	RESIDENCE OF DECEDENT			- Cann	711460		Doren	CSCCI		
DIRECTOR	Maryland Dorchester Vienna 106. COUNTY 106. CITY, TOWN OR LOCATION 106.									
BY FUNERAL	100. STREET AND NUMBER 108 Church Street			101	10g. CITIZEN OF	WHAT COUNTRY?				
2	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 1 Never Married 2 Merried 1 Never Married 2 Merried 1 Never Married 2 Merried 1 YES, GIVE WAR OR DATES 1 YES, 2 NO Specify: Specify									
	3 X Widowed 4 Divorced				M spoon			ow: White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	TON mpleted)	16a. DECEDENT'S US (Give kind of work	done during mo	N st of working	16b. KIND OF BU	SINESS/INDUSTRY			
֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡֡	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	,		Comm	ent Indu	at ww		
NIC.	17. FATHER'S NAME (First, Middle, Last)		Seams	tress				stry		
	Joseph Lewis					ME (First, Middle, Melden la Hughes	Surname)			
2	19a. INFORMANT'S NAME (Type/Print)		195 MAILING AD	DRESS (Street e		Route Number, City or Tow	e Chin Zin Cada)			
2	Roscoe D. Davenpor	't	P.O. Bo	x 113	rankfor	d, Delawar	e 19945			
ţ	204. METHOD OF DISPOSITION		PLACEANDDATEOF	DISPOSITION (Ne	me of			own, Slata		
1 M Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) The Removal from State Competery, crametory or other place) St. Paul's P.E. Cemetery 9/28 Vienna, Maryland										
	23. PART (Entar the diseases, or con	nplications that caused	the death. Do not	anter tha mo	de of dying, suc	h as cardisc or read	ratory arrest.	Approximate		
	ahock, or haart failure. Lia iMMEDIATE CAUSE (Final	it only one causa on ea	ch iina.					Interval Between Onset and Death		
	disease or condition resulting in death)									
	DUE TO (OR AS A CONSEQUENCE OF):									
۱ ا	Sequentially list conditions, b. CHD									
CERTIFICATION	if any, issding to immediata	DUE TO (OR AS A	CONSEQUENCE OF):							
2	CAUSE (Disease or injury	DUE TO (OD AC A	CONGEONIENCE OF							
	that initiated events resulting in death) LAST	DOE TO (ON AS A T	CONSEQUENCE OF):							
5	d						1565			
:	PART II. Other aignificant conditions of	contributing to death bu		ha undarlying	cause given in	Part i. 24a. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDIC	NDOM AT	MAL FIR	.			1 _ YES 2	1	COMPLETION OF CAUSE OF DEATH?		
_						_/		1 TYES 2 NO		
	DID TOBACCO USE CONTRIE				UNCERTAIL	10				
SICIAN		IOSPITAL:		THER.						
	1 YES 2 No 1	☐ Inpetient 2 ☐ ER/Outpet	tient 3 DOA 4			6 Other (Specify)	N DIEV CONTES			
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WO	RK?	200. DESCRIBE HOW I	NJURY OCCURED			
3	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY -	– Al home, term, stree			261. LOCATION (Street a	and Number or Rural	Route Number.		
	4 Homicide determined	building, atc. (Specif	y)		i	City or Town, State)				
	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	dge, death occurred a	t the time, date	and place, and due	to the cause(s) and mer	oper se stated			
	(Check only one) 2 MEDICAL EXAMINER: (a) and manner sa stated.		
}	296. SIGNATURE AND TITLE OF CERTIFIED				29c. LICENSE NUR			O (Month, Day, Year)		
5	Wilkuta	Show	A		222-	173	D 9/2	27195		
:	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	H (ITEM 27) Jupe, Pri	nt)	LINO	(/_)	110	-/()		
	HUBERT	W FIERY!	105 3	03	BYRIN	ST CA	mB an	i = rucl		
	31. DATE FILED (Month, Day, Year)	Sala Dancles	P. J.II		7					
	SEP2 8 1995	HATTA BURNOLAGO	MANAGE !							

R ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE 0	F MARYLAND	/ DEPAR	TMENT	OF H	EALTH AND	MENTAL HYGIENI	E					
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DA	V VE	3. TIME OF OEATH				
		Blanche Lusetta		rake				09 20	1995	5 12:15 PM				
Pin		4. SOCIAL SECURITY NUMBER 5. SEX 1 1 M 2 X		35 YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 07/10/1910	Su	ountry) Ittolk, Virginia				
3 should	E	9s. FACILITY NAME (If not institution, give street and number)				OR LOCATION OF D	EATN	9c. COUNTY					
1, 2,	стов	4614 Harris Street RESIDENCE OF DECEDENT 100. STATE 100. COUNTY				enna			Dorch	ester				
permit, Pages	. DIRE	Maryland Dorchester			v, town o ienna	R LOCAT	TION		_	10d. INSIGE CITY LIMITS? 1 YES 2 K NO				
sit peri	FUNERAL	100. STREET AND NUMBER 4614 Harris Street					21869		USA	OF WHAT COUNTRY?				
020 physician. burial-transit	N	11. MARITAL STATUS 12. WAS DECI	DENT EVER IN U.S.		13. V	WAS DEC	ENGENT OF HISPAI	VIC ORIGIN? (Specify Yes	RACE — American Indian,					
Z15-0020 attending physic se as the burial	B		1 YES 2 X VE WAR OR DATES	th yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: African American										
21 atte	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. I	DECEDENT'S (Give kind of the Do NOT us	USUAL OC	CUPATIO	ON est of working	16b. KIND OF BUS						
AND 21 the hospital or detached for u	COMPLET	8th grade College (1-4 of	N 0 +)	mesti				Private	e Famil	ly Homes				
	SO	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Malden S		,				
ay be retained by page 5 should be be notified at	BE	William Skinner							Marzella Aaron or or Rural Route Number, City or Town, State, Zip Code)					
	٥	Mrs. Martha Boone Pinkett	F	P. O.	Box 1	71 -	- Vienna	, Maryland	21869	"				
I E . WI		20e. METHOD OF DISPOSITION 1XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery c	e and date of the second secon	ther place)			DATE 200. LOG	ation city of	Comment of the Commen				
BALLIMO or death. Page 6 r he funeral director al.	į	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. N	AME AN	D ADDRESS OF FA	CILITY Jolley M	emoria	Chapel				
s after dea to by the fur removal.		Patrusa (1 St	lley		12	13 .	Jersey Ro	oad - Salisbu	ry, Ma	ryland 21801				
5 5 0		23. PART i. Enter the diseases, or complications shock, or heert failure. List only one	cause on each iir	death. Do r	not enter	the mo	- 1	4		Approximate interval Between				
4 fig # 24		iMMEDIATE CAUSE (Final disesse or condition resulting in death)	Kme	ne	the) (llys	lumes	14	Onset and Death				
8 6 4 6	_	DUI	DUE TO 10th AS A CONSEQUENCE OF:											
. 8 " O FI	CATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING												
D E E E	E S	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
7 E E E	ERTIFI	resulting in death) LAST												
_ > 2 -	AL C	PART II. Other aignificent conditions contributing	to death but not	resulting	in the unc	derlying	ceuse given in	Part i. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
L KECOKI law requires that th as been signed by t lept, of Health and 23 shows any in	EDIC/				_			1 TYES 2		COMPLETION OF CAUSE OF DEATH?				
St. of Ge	Σ	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DE	ATH YE	S D N	10 🗆	UNCERTAIL	<u>-</u> -		1 YES 2 MO				
E B B B	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL	ACE OF DEAT		nly one)								
SICIAN: The certificate It is the State Id. or item	14SI	1 YES 2 NO 1 Inpatient	2 ER/Outpatient OF INJURY	3 DOA	4 - Nursi	ing Home		6 Other (Specify)						
그 문을 들이	ву Рн		th, Day, Year)		URY		RK?	28d. DESCRIBE NOW IN	JURY OCCURE)				
TTENDI TTENDI TTOR: A after d	8	3 Suicide 28s. PLA	CE OF INJURY — AI I ling, atc. (Specify)	nome, farm, s	street, facto	ry, office		26f. LOCATION (Street or City or Town, State)	nd Number or Ru	rel Route Number,				
AL OR	APLET	29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the be												
THE HOSPITAL THE FUNERAL fled within 72 PORTANT: It i	COMPI	MEDICAL EXAMINER: On the basia	of examination and/o	r investigatio	n, in my op	olnion, de								
TO THE HOSPIT TO THE FUNER De filed within 7	BE	Charles and the contract of	Wash	who	M	7	29c. LICHNISE NUI	JBER O	▶ 9 /3	NED ONLY DOL MAD				
5 =	٩	36. NAME AND ADDRESS OF PERSON WWO COMPLETED	CAUSE OF DEATH (IT	EW 27 /7904	Armer)	-/-		109	1	10				
		31. DATE FILED (Month, Day, Year) 32 REGIS	TRAR'S SIGNATURE		-	_			- /-					
		SEP 25 1995 Julia	TRANS BIGHATURE	dall										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a first hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

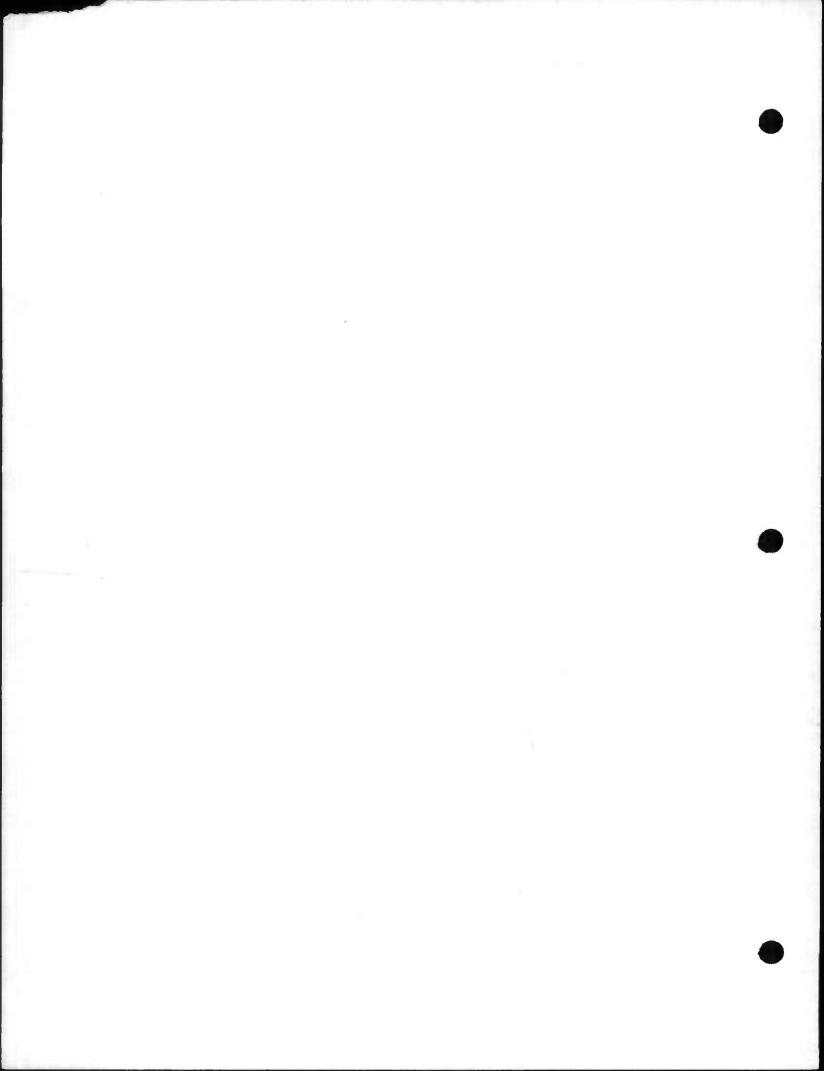
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Amended 10/10/95 Item #26 W.C.H.D. mpt
FOR STATE OF MARYLAND / DEPARTMEN

	1 - STATE REGISTRAR				ICATE	OF	DEAT		MENTA	REG. NO.							
	1. DECEOENT'S NAME (First, Middle, L	151)					-	-	2. DATE	OF DEATH			3. TIME OF DEATH				
- 8	PETER				7	CC	KEN	,	MONTI	en san		YEAR					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH			PLACE (State or Foreign				
	140-26-8136	1 🙀 M 2 🗆 F	61	YRS.	MONTHS	DAYS	HOURS	MIN.		n, Day, Year)		Country)				
	9e. FACILITY NAME (If not inetitution, g	ve street and number)			9b. CITY	TOWN O	R LOCATIO	ON OF DE		iber 12.	12,1933 New Jersey						
E I	PENINSULA REGIO	AL CENTER	2			BURY					ICOM						
DIRECTOR	RESIDENCE OF DECEDENT										10011	100					
R	10a. STATE 10b. COL				CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?				
	Maryland	Wicomico	Salisbury				9					1 X YES 2 NO					
3AL	10e. STREET AND NUMBER				10f.	ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
FUNERAL	740 S. Park D		21801					USA									
2	11. MARITAL STATUS 1 Never Married 2 Merried		ENT EVER IN U.S. ARMED 13. WAS 1 YES 2 X NO It ve			WAS DECI	ENDENT O	F HISPAN	NIC ORIGIN	? (Specify Yee	or No-	14. RACE Black	- American Indian, White, etc.				
BY	3 Widowed 4 Divorced	IF YES, GIVE V		0	If yes, specify Cuben, Mexican 1 YES 2 Y NO Specify:			y: Specify:			r.						
	15. DECEDENT'S	EDUCATION	10- 000	DEBENITIO.					Whi				te				
E	(Specify only highest g	rade completed)	NTION 16a. DECEDENT'S USUA (Give kind of work d life. Do NOT use retir				N I of workin	g	16b.	KIND OF BUS	INESS/IND	JSTRY					
7	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Dietary Manager				Food Service									
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, N														
	John George D	ecker								rude l							
BE	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS	(Street or				per, City or Town		Codel					
2	Virginia Decke	c								iry, M							
	20a. METHOD OF DISPOSITION		20b. PLACE A	ND DATE (OF DISPOS	ITION (Nar	ne of		OAT	20c, LOC	CATION — C	ity or Tow	rn. State				
- 1	1 Burial 2 S Cremation 3 F 4 Donation 5 Other (Specify)	Salis	burv	ther place)	nato	rv		9/		lisbu							
	21. SIGNATURE OF EMPERAL SERVICE	LICENSEE	2		22.	NAME AN	O ADDRES	S OF FA	CILITY			,					
	won!	73 4							Home								
	23. PART I. Enter the diseases,	or complications the	t cettined the dea	nth Do r	ot enter	501	Snow	Hi	L1 Rd	. Sal	isbu	ry,MI					
	ahock, or heart fallu	re. List only one cat	ise og each line.	5			•					rest,	Approximate interval Between				
	iMMEDIATE CAUSE (Finel disease or condition	20	(OM AS A CONSEO Om as A CONSEO	20	F	-	1,0						2 week				
	resulting in death)	(OR AS A CONSEO	UENCE &	7 F):	-11/		~	- /		6 Weeks							
_		hie	24	1-	1	F	31/6	n			Ligen						
<u> </u>	Sequentially list conditions, if any, leeding to immediate	(OR AS A CONSEO	UENCE O	F):								T					
8	cause. Enter UNDERLYING CAUSE (Disease or injury	. 0	2591 ~	sich premonin									INREK				
E	that initiated eventa	DUE TO	(OR AS A CONSEO	UENCE O	F):												
CERTIFICATION	resulting in death) LAST	d															
	PART II. Other algnificent condi	lons contributing to	deeth but not re	aulting	in the un	derivina	ceuee o	lven in	Pert I	24a, WAS AN	MITTOPEY	T 245 1	WERE AUTOPSY FINDINGS				
										PERFORI			AVAILABLE PRIOR TO				
CAL			a chi	220	106	1160	~	27		Metastatu flea chromocytema. PERFORMEDY AMILAE COMPLE							
	metasto		a ch	270	100	yto	~~	n.	_	1 TYES 2	☑ NO		COMPLETION OF CAUSE OF GEATH?				
	metasta	ter fre								1 TYES 2	NO		COMPLETION OF CAUSE				
	DID TOBACCO USE.CO	TEN STRIBUTE TO CA	USE OF DEAT	TH YE	S 🗆 1	40 D		ERTAIN	- 	1 TYES 2	⊠ NO		COMPLETION OF CAUSE OF GEATH?				
	DID TOBACCO USE.CO	NTRIBUTE TO CA	USE OF DEAT	TH YE	S	NO only one)	UNC	ERTAIN			NO		COMPLETION OF CAUSE OF GEATH?				
	DID TOBACCO USE.COI 25. WAS CASE REFERRED TO MEDICA EXAMINER?	NTRIBUTE TO CA HOSPITAL: 1 W Inputiont 2) 26e. DATE OF	26. PLACE	H YE OF DEAT	S	NO Donly one) It: Ing Home 28c. INJU	UNC	ERTAIN	6 Other	(Specify)			COMPLETION OF CAUSE OF GEATH?				
PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	NTRIBUTE TO CA HOSPITAL: 1 M Inputient 2) 26e. DATE OF (Month, D	26. PLACE	H YE OF DEAT	S	NO Donly one)	UNC	ERTAIN	6 Other				COMPLETION OF CAUSE OF GEATH?				
BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 2 Accident	NTRIBUTE TO CA HOSPITAL: 1 M Inputlent 2) 28e. DATE OF (Month, D)	28. PLACE 28. PLACE 28. PLACE ER/Outpetient 3 INJURY ay, 'Year') FINJURY — At hon	OF DEAT	OTHEF 4 Num	NO Donly one) 1: Isling Home 28c. INJU WOF 1 Y	UNC 5 Re DRY AT RK7 ES 2	ERTAIN	6 Other 28d. DES	(Specify) CRIBE HOW IN	JURY OCCI	URED	COMPLETION OF CAUSE OF CEATH?				
BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 Yes 2 NO 27. MANNER GE-DEATH 1- Netural 5 Pending Investigati	NTRIBUTE TO CA HOSPITAL: 1 (M inpatient 2) 28e. DATE OF (Month, D 28e. PLACE O building.	26. PLACE 26. PLACE 27. PLACE 28. PLACE 28. PLACE 28. PLACE 29. PL	OF DEAT	OTHEF 4 Num	NO Donly one) 1: Isling Home 28c. INJU WOF 1 Y	UNC 5 Re DRY AT RK7 ES 2	ERTAIN	6 Other 28d. DES	(Specify)	JURY OCCI	URED	COMPLETION OF CAUSE OF CEATH?				
BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not 4 Homicide 6 Could not	NTRIBUTE TO CA HOSPITAL: 1 M Inpetient 2) 28e. DATE OF (Month, D) 28e. PLACE O building,	26. PLACE 26. PLACE 27. PLACE 28. PLACE 28. PLACE 29. PL	E OF DEAT	OTHER 4 UNITY M street, factor	only one) t: sing Home 28c. INJU WOF 1 YO	UNC 5 Re	ERTAIN sidence	6 Other 28d. DE\$	(Specify) CRIBE HOW IN ATION (Street er Town, Stete)	IJURY OCCI	URED or Rural Ro	COMPLETION OF CAUSE OF CEATH?				
BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not determine 29e. CERTIFIER (Check only) 1 CERTIFYING PR	NTRIBUTE TO CA HOSPITAL: 1 M Inpetient 2 26e. DATE OF (Month, D) 26e. PLACE O building,	26. PLACE 26. PLACE 27. PLACE 28. PLACE 28. PLACE 29. PL	DOA 28b. TIM INJ	S TH (Check of OTHEF 4 In Number OF URY M	only one) t: sing Home 28c. INJU WOF t	UNC 5 Re IRY AT NK? ES 2 Bend piece,	ERTAIN sidence NO end due	6 Other 28d. DES 28f. LOC/	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete)	IJURY OCCI	URED or Rural Ro	COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO				
COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not 4 Homicide determine 29e. CERTIFIER (Check only 000) 2 MEDICAL EXAM	NTRIBUTE TO CA HOSPITAL: 1 W Inputent 2) 28e. DATE OF (Month, D) 28e. PLACE O building, and a second sec	26. PLACE 26. PLACE 27. PLACE 28. PLACE 28. PLACE 29. PL	DOA 28b. TIM INJ	S TH (Check of OTHEF 4 In Number OF URY M	only one) t: sing Home 28c. INJU WOF t	UNC 5 Re 187 AT 1K? ES 2 and plece, with occurrent	ERTAIN sidence NO end due	8 Other 28d. DE\$ 28f. LOC: City to the ceu	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete)	IJURY OCCI	URED or Rural Ro d. ceuse(e)	COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO unter Number,				
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not determine 29e. CERTIFIER (Check only) 1 CERTIFYING PR	NTRIBUTE TO CA HOSPITAL: 1 W Inputent 2) 28e. DATE OF (Month, D) 28e. PLACE O building, and a second sec	26. PLACE 26. PLACE 27. PLACE 28. PLACE 28. PLACE 29. PL	DOA 28b. TIM INJ	S TH (Check of OTHEF 4 In Number OF URY M	only one) t: sing Home 28c. INJU WOF t	UNC 5 Re IRY AT NK? ES 2 Bend piece,	ERTAIN sidence NO end due	8 Other 28d. DE\$ 28f. LOC: City to the ceu	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete)	IJURY OCCI	URED or Rural Ro d. ceuse(e)	COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO				
E COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE.COI 25. WAS CASE REFERRIED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not 4 Homicide determine 290. CERTIFIER (Check only One) 2 MEDICAL EXAN 290. SIGNATUBE AND TITLE OF CERTIFIER	NTRIBUTE TO CA HOSPITAL: 1 M Inpettent 2) 28e. DATE OF (Month, D building, I see of e times. To the best of times: On the best of e times.	28. PLACE 28. PLACE 28. PLACE ER/Outpetient 3 INJURY ey, 'Year') FINJURY — At hon atc. (Specify) my knowledge, dea xamination end/or in	TH YE OF DEAT	S	NO Donly one) 1: sling Home 28c. INJU WOF 1 YI Dory, office	UNC 5 - Re JRY AT RK? ES 2 - and plece, and poccur 20c. LICE	end due od at the	28d. DE\$ 28f. LOC: City to the countime, date	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete) se(e) and mane	nd Number of Num	d. ceuse(e)	COMPLETION OF CAUSE OF CAUSE OF CEATH? 1 YES 2 NO ute Number, end menner ee stated. Month, Day, Year)				
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE.COI 25. WAS CASE REFERRIED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 6 Could not 4 Homicide determine 290. CERTIFIER (Check only One) 2 MEDICAL EXAN 290. SIGNATUBE AND TITLE OF CERTIFIER	NTRIBUTE TO CA HOSPITAL: 1 W Inputent 2) 28e. DATE OF (Month, D) 28e. PLACE O building, and a second sec	28. PLACE 28. PLACE 28. PLACE ER/Outpetient 3 INJURY ey, 'Year') FINJURY — At hon atc. (Specify) my knowledge, dea xamination end/or in	TH YE OF DEAT	S	NO Donly one) 1: sling Home 28c. INJU WOF 1 YI Dory, office	UNC 5 - Re JRY AT RK? ES 2 - and plece, and poccur 20c. LICE	end due od at the	28d. DE\$ 28f. LOC: City to the countime, date	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete) se(e) and mane	nd Number of Num	d. ceuse(e)	COMPLETION OF CAUSE OF CAUSE OF CEATH? 1 YES 2 NO ute Number, end menner ee stated. Month, Day, Year)				
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE.CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending Investigate 3 Suicide 6 Could not 4 Homicide determine 29e. CERTIFIER 1 CERTIFYING PI (Check only One) 2 MEDICAL EXAM 29b. SUSNATUBE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON 31. DATE FILEO (Month, Dev. Year)	NTRIBUTE TO CA HOSPITAL: 1 M Inpatient 2 26e. DATE OF (Month, D be 1 28e. PLACE O building, 1 1YSICIAN: To the best of INNER: On the basic of e	28. PLACE 28. PLACE 28. PLACE ER/Outpetient 3 INJURY ey, 'Year') FINJURY — At hon atc. (Specify) my knowledge, dea xamination end/or in	TH YE E OF DEAT 28b. TIM INJ ne, term, s th occurrencestigation	S	NO Donly one) 1: sling Home 28c. INJU WOF 1 YI Dory, office	UNC 5 - Re JRY AT RK? ES 2 - and plece, and poccur 20c. LICE	end due od at the	28d. DE\$ 28f. LOC: City to the countime, date	(Specify) CRIBE HOW IN ATION (Street er or Town, Stete) se(e) and mane	nd Number of Num	d. ceuse(e)	COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO unter Number,				

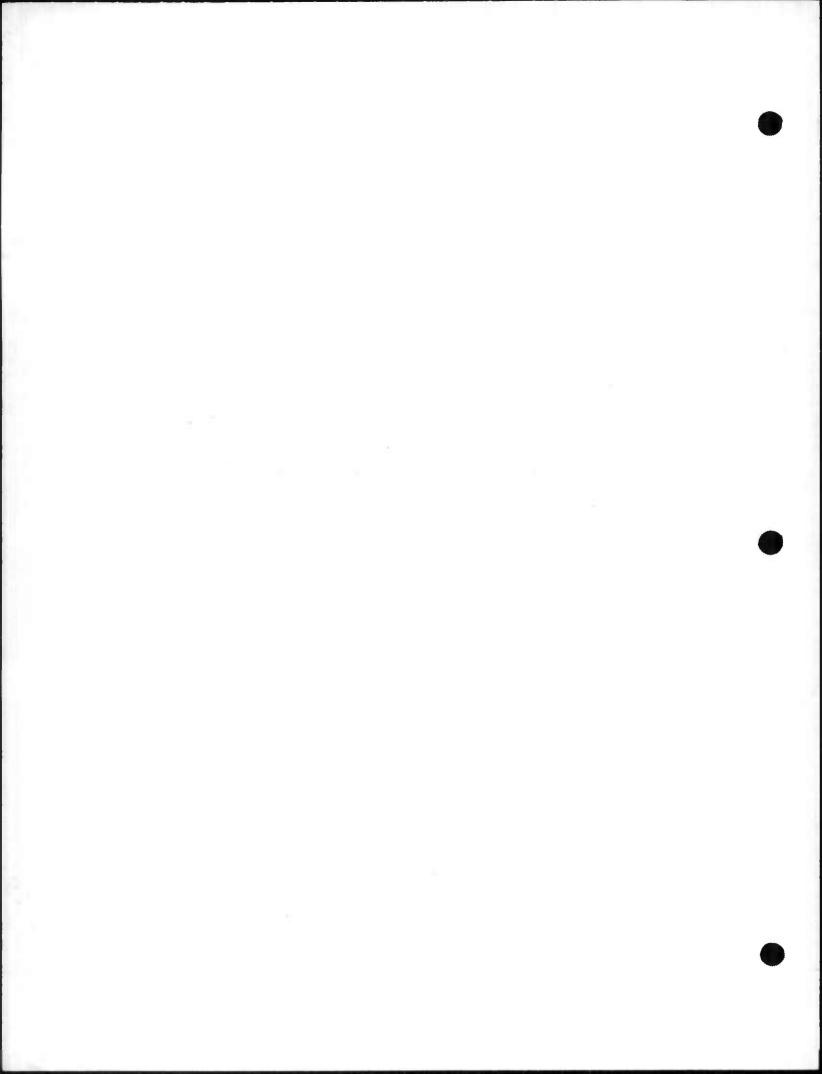


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	NTAL HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	REGISTRAR		CI	ERTIF	ICATE (OF DEATH	REG. N	0.		
	1. DECEDENT'S NAME (First, Middle, Last) Joan Muir	Dolan					2. DATE OF DEATH MONTH October 1	DAY 1.00 ²	YEAR	4:36 pm
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	it birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BURTH		6. BIRTHPL	ACE (State or Foreign
	578-24-2119 1 \(\text{\text{\$\exititt{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}\$\text{\$\exitititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\tex{					July 5,	1925	New Y	York	
	Se. FACILITY NAME (If not institution, give st		9b. CITY, TOWN OR LOCATION OF DEATN			9c. COUNTY OF DEATN				
DIRECTOR	Frederick Memorial Hospital Frederick Frederic								ck	
E C	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATION			1	0d. INSIDE CITY
5	Maryland Fred									LIMITS?
	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZ		AT COUNTRY?	
FUNERAL	6889 Buttonwood Co	ourt				21701		U.S.A.		
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVENT FORCES? 1	YES 2 X	NO	If yes	s, specify Cuban, Mexic	NIC ORIGIN? (Specify) an, Puerto Rican, etc.)	es or No-	I4. RACE - Black, \	- American Indian, White, etc.
2	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 🗆	YES 2 NO Spec	rry:		Specify:	White
í	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			CEDENT'S	USUAL OCCU	PATION	16b. KIND OF B	USINESS/INDU	STRY	
	Elementary/Secondary (0-12) College (1-4 or 5+)			. Do NOT u	se retired.)	g most of working				
	12 years			Sup	erviso		None			
COMPLE	17. FATHER'S NAME (First, Middle, Lest) Joseph Francis Ma	ıir			18. MOTNER'S NAME (First, Middle, Maiden Surname) Elizabeth Maloy					
7	19e. INFORMANT'S NAME (Type/Print)			h MAILING	ADDRESS (SM		Route Number, City or R	State 7/a /	Carda)	
2	Austin E. Dolan						Frederic			d 21701
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo	20b. PLACE	AND DATE	OF DISPOSITIO	N (Name of		OCATION — C	_		
Į	4 Donation 5 Other (Specify)		Gate	Of H		Cemetery				, Maryland
	21. SIGNATUME OF FINEBAL SERVICE LIC	8	2.0	. /	ROB	ERT E. DA	LEY & SON	FUNER	AL HO	OMES, P.A.
	Spare	Mas	sey	77	120	1 NORTH MA	ARKET ST.	FREDER	ICK,	
	23. PAHT I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	IMMEDIATE CAUSE (Final									Onset and Death
	resulting in death) a. UNE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
	- VENTRICULAR ASUSTNE									
	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							1		
	cause, Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								
orum icalion	d									
TO LOUIS	PART II. Other aignificant conditions				in the under	lying cause given in		N AUTOPSY DRMED?		ERE AUTOPSY FINDINGS
	_ Ischemic	CARDIOM	YOPA	Thy			1 □ YES	2× NO		OMPLETION OF CAUSE F DEATN?
	DID TORACCO LISE CONTR	IDITE TO CALIC	E OF DEA	TII W	. П. N.O.	П			1	YES 2 NO
SICIAN	DID TOBACCO USE CONTR	IBUTE TO CAUS			IN (Check only		иП			
5	EXAMINER?	HOSPITAL:	l/Outpatient 3	□ DOA	OTHER:	Home 5 - Residence	6 Other (Specify)			
בו	27. MANNER OF DEATN	28e. DATE OF thJ (Month, Day,)		28b. TIM	-	INJURY AT WORK?	28d. DESCRIBE NOW	INJURY OCCL	RED	
	1 Natural 5 Pending 2 Accident Investigation				M 1	YES 2 NO				
3	3 Suicide 6 Could not be 4 Homicide datarmined	28e. PLACE OF IN building, atc.	(Specify)	me, farm,	street, factory,	offica	261. LOCATION (Stree City or Town, Stat	and Number o	r Rural Rou	rte Number,
	29e. CERTIFIER									
COMPL	(Check only one) 2 MEDICAL EXAMINER						to the cause(a) and m			ad manage on eterid
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER	. / / / /			, y op.inc	29c. LICENSE NU		T		
2	Sm A.	Istasello 1	20			D27	/			
	30. NAME AND ADD 12-3 OF PERSON WHO	COMPLETED CAUSE O	OF DEATH (TE	М 27) (Туре,	. Print)	105/0	, , ,	1	111=0	
	John A. Vitarello	M.D. 310	West	9th	Street	, Frederic	k, Maryla	nd 217	01	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE							
- 1	OCT 0 4 1995	72	walson h	201.00						

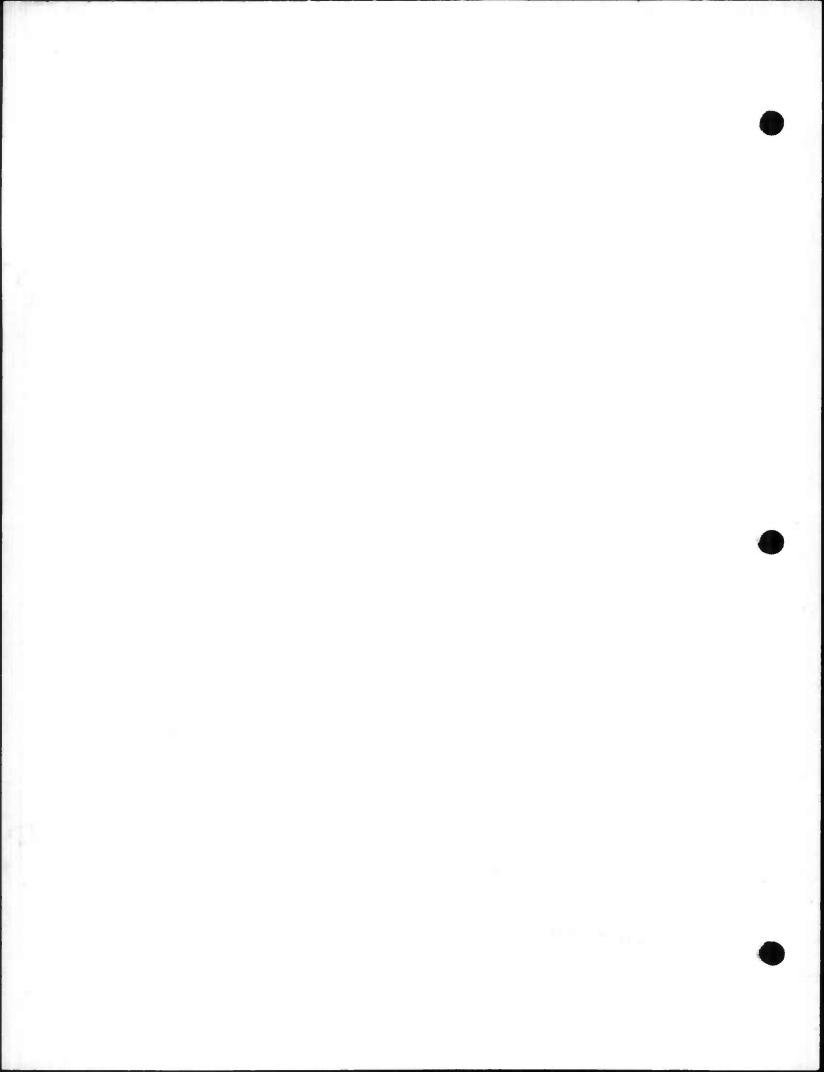


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

certificate be executed with. 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with an antended the control of the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	EALTH AND	MENTA	L HYGIEN			
	DECEDENT'S NAME (First, Middle, Last) Barbara	Unknown	de Gr			2. DATE MONT Set	of DEATH		YEAR 5	3. TIME OF DEATH 2:30 PM M
	0/1 0/ 0100	5. SEX 6. AGE 1 N 2 XXF 8	(In yrs. lest birthday) 6 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH		8. BIRTI	IPLACE (State or Foreign
OR	•• FACILITY NAME (If not Institution, give stre Frederick Memoria	et and number) il Hospital		Preder	ick			9c. COUN		eath rick
DIRECTOR	10s. STATE 10b. COUNTY Maryland Freder	rick		y, town on Local Frederic					10d. INSIDE CITY LIMITS?	
FUNERAL	10e. STREET AND NUMBER 313 Heather Ri	dge Drive	1	101	21702				TIZEN OF WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	Never Married 2 ☐ Married FORCES? 1 ☐ YES 2 ♣ NO				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yee, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify: Sp				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker						Own H		USTRY	White
BE CON	17. FATHER'S NAME (First, Middle, Lest) Unknown	Blan	ke		16. MOTHER'S N	sabel			utle	r
10	196. IMPORMANT'S NAME (Type/Print) Henry de Gruchy 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 West Patrick Street, Frederick, Maryland 21702									
	20e. METHOD OF DISPOSITION 1 Burtal 2 A Cremation 3 Remov 4 Donation 5 Other (Specify)		PLACE AND DATE OF STREET OF STREET	Crematory	Oct. 2, 1			thsbu		wn, state Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENTA	that M	00255	Keene 106 E	y and Baast Chui	asfor	t. Fr	ederi	ck	Home Md, 21701
	23. PART I. Enter the diseases, or co- shock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	et only one cause on a	I tha death. Do rach iina.	not anter the mo	de of dying, au	ch as care	diec or respi	ratory arm	eat,	Approximate interval Between Onset and Desth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other significant conditions Dengaration Double DID TOBACCO USE CONTRI	n In	poluon	Ce		Pert I. 24e. WAS AN AUTOPSY PERFORMED?			24b.	WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
BY PHYS	1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	Inpatient 2 ER/Outp 28a, DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO		_	r (Specify)	NJURY OCC	URED	
	3 Sulcide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, s	street, factory, office		281. LOC City	ATION (Street a or Yown, State)	nd Number	or Aural A	oute Number,
COMPLET		On the basis of exemination								and manner as stated.
TO BE C	286. SIGMATURE AND TITLE OF CENTERER				D 319					(Month, Day, Ybar)
	Dr. Julio Menocal	MD 1564 Op	ossumtow	m Pike,	Frederi	.ck, 1	Marylai	nd 21	702	
	31. DATE FILED (MOOTH) 07 4" 1995	32 REGISTRATE SIGN	ATURE RANGELLI					-		



death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

funeral director, page 5 should be detached for use as the burial-transit

and completely filled in by the burial, cremation, or removal.

9

physician prior

attending

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been signed by the pt. of Health and N

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After

DIRECTOR: /

FUNERAL I

Robert

S.

1995

32. REGISTRAR'S SIGNATURE

In Davidson Real 11

Dr.

31. DATE FILAD (41 orth, Day, Yoar)

Pages 1, 2, 3 should

permit.

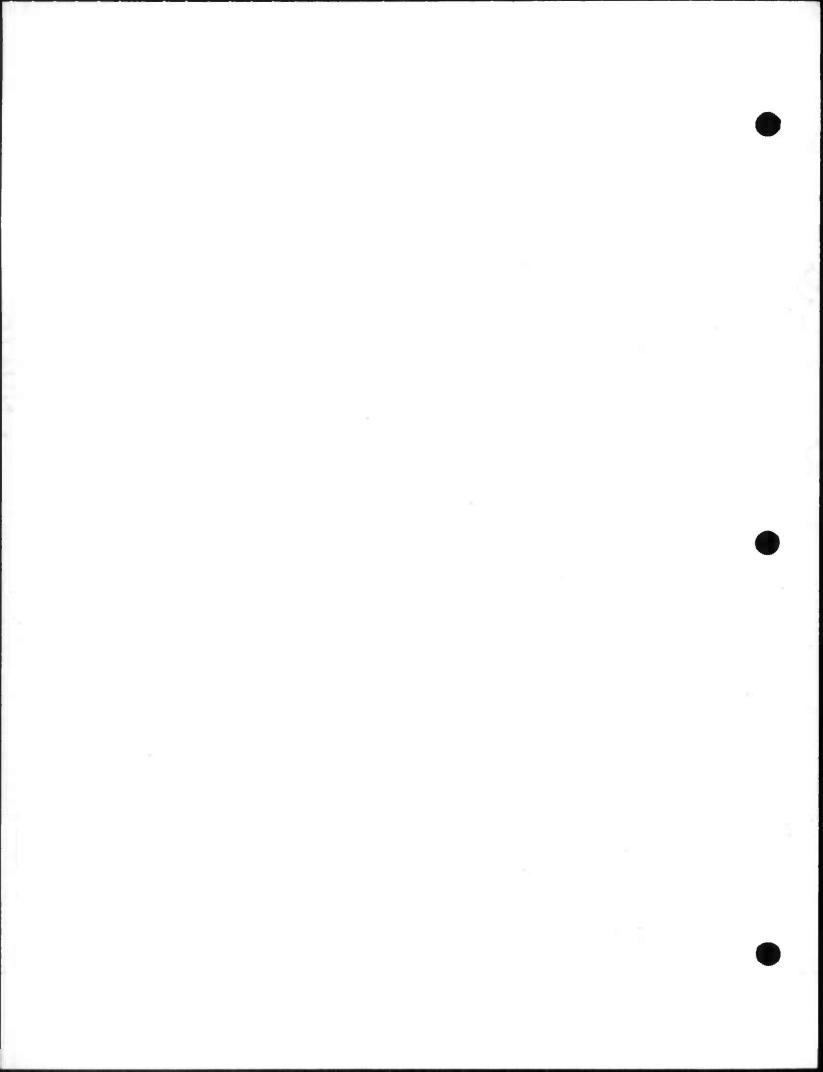
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH KENNETH DIXON Sept. 1995 **JAMES** 25, 3:00 P.M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 1 🔣 M 2 🗌 710-09-6270 YRS. 76 Nov. 16, 1918 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF CEATH DIRECTOR Young 1121 Place Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1121 Young Place 21702 United States 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, DIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: W.W. II White 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high E (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 7th Engineer B. & O. Railroad at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) HARRY DIXON BE LEONA NORTHCRAFT notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy C. Dixon 1005 Young Place / Frederick, Maryland 21702 must be 20a. METHOD OF DISPOSITION
1 Suriat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF OISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Burist 2 Cremation 3 R 4 Donation 8 Other (Specify) Park Heights Cemetery 9-28 Brunswick, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home the medical examiner 1621 Opossumtown Pike/ Frederick, Md. 21702 23. PART I. Engle the diseases, or complications that caused the december, or heart failure. List only one cause on each line. m, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) la teles traumatic event, DUE TOUGH AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 YES 2 THO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 12 NO 12 UNCERTAIN 12 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) The The HOSPITAL OTHER 4 □ Bursing Home 5 □ Desidence 6 □ Other (Specify) 1 YES 2 NO 1 - Inpatient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCUREO marked, 1 Metural 5 Pending 1 YES 2 NO В 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 28 is 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 📋 Homicide tem 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. Ξ TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month. B 29c. LICENSE NUMBER felit 26, wile 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Hughes, 700 Montclaire Ave./ Frederick, Md.

21701



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

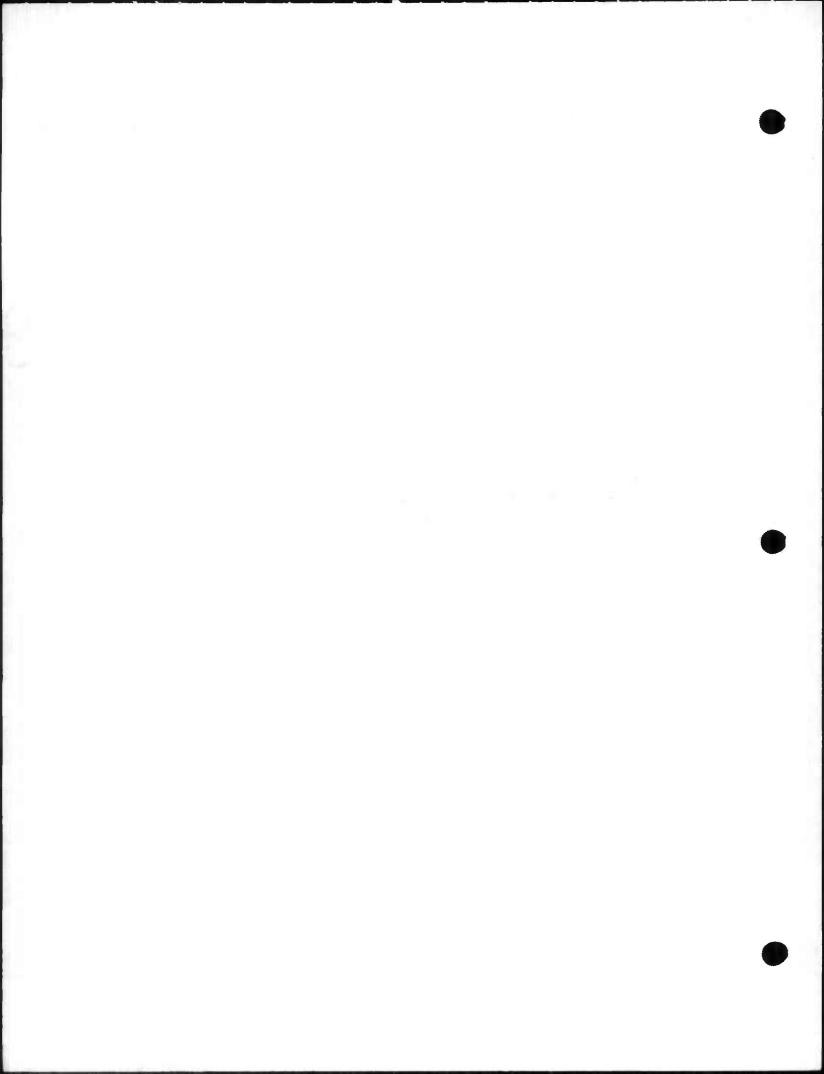
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

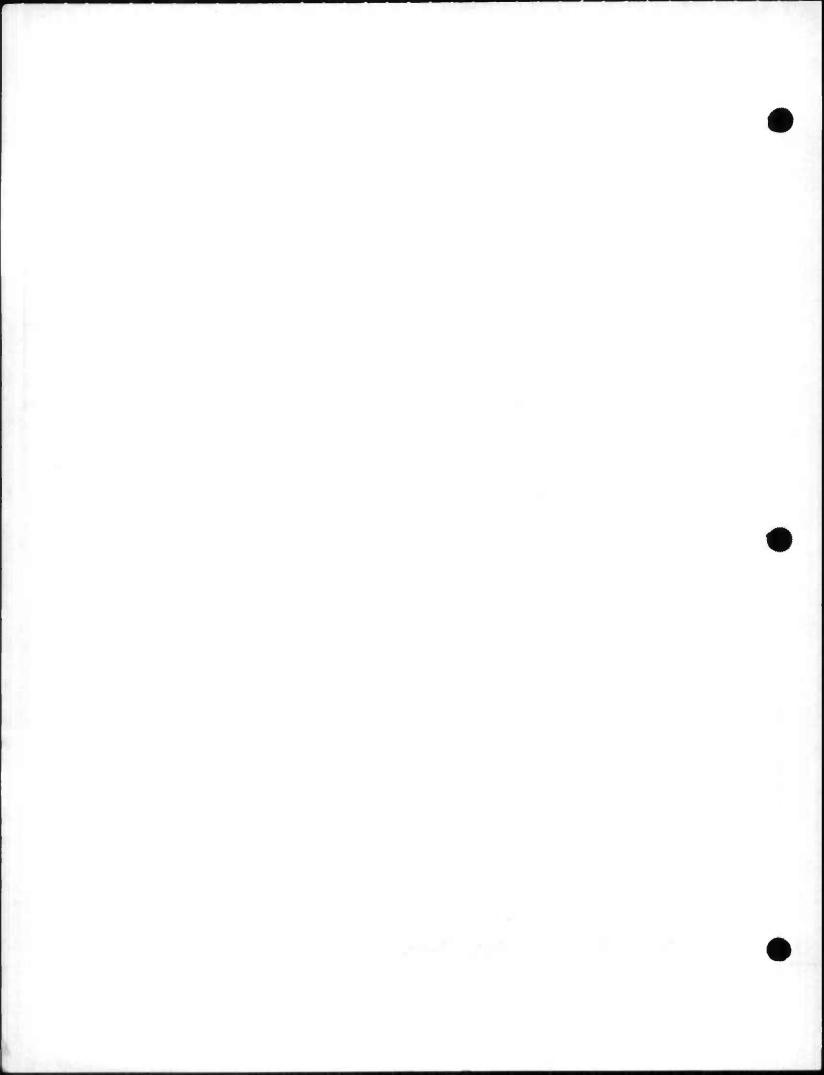
	REGISTRAN		C	ENTIF	CALE	UF	DEAL	П	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	HENF	v			2	IK	5	2. DATE OF	DA	14.19	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. Ia	at bloth doub	IF UNDER 1	-	K13		Septemb		14,17		1411 PM
	The second secon	1. J. M 2 □ F		YRS.		DAYS	HOURS	MIN.	7. DATE OF I	v. Year)		Country	PLACE (State or Foreign
	070-18-5238		86	THS.					2-10	-09		NEW	HAVEN, CONN.
œ	9a. FACILITY NAME (If not institution, give at		053155				R LOCATION	OF DEA	TH		9c. COUI	NTY OF DE	ATH
DIRECTOR	PENINSULA REGIONA	CENTE	R	SA	LIS	BURY				W	ICOM	ICO	
ត្ត	RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY		10c, CITY, TOWN OR LOCATION										
<u>E</u>				-			ON						10d. INSIDE CITY LIMITS?
		NGS			BROOK								1XXYES 2 □ NO
FUNERAL	10e. STREET AND NUMBER					10f.	ZIP CODE				10g. CITI	ZEN OF W	HAT COUNTRY?
ÿ	575 HERKIMER ST					1121	3				U.S	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1	VER IN U.S. AF	RMED	13. W	S DECE	NDENT OF	HISPANIC	ORIOIN? (S	pecify Yes	or No-	14. RACE	- American Indian,
ВУ	1 Never Married 2 Married 3XX Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES		10	YES:		Specify:	Puerto Ricar	n, etc.)		Specifi	. White, etc.
							AA						BLACK
回	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)			USUAL OCC				16b. KIN	D OF BUS	INESS/IND	USTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	- We	. Do NOT us	e retired.)								
7	8		(CLERK					AUT	3 O	FOOD	SERV	/ICE
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					T	18. MOTHE	R'S NAM	E (First, Middle	s, Malden S	Sumame)		
BE (HENRY ELKS							MAUE	E HAR	DY			
2	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street an	d Number or	Rural Ro	ute Number, C	ity or Town	, State, Zip	Code)	
F	ROBERT HUNTER		1	575 H	ERKIM	ER :	ST.,	BROC	KLYN,	N.Y	. 1	1213	
	20a. METHOD OF DISPOSITION		20b. PLACE	ANDDATEC	F DISPOSITI	ON (Nerr	ne of		DATE	20c. LOC	ATION —	City or Tow	m. State
	1 Buriel 2 X Cremetion 3 Remo	SALISI	BURY or of	ner place) CREMA	TOR	y 9-	26-9	5	SAL	ISBUI	RY. N	ID.	
- 1	21. BIGHATURE OF FUNDIAL SERVICE LICE	ENSEE	_		22. NA	ME AND	D ADDRESS	OF FACIL	LITY			,	
- 1	166	10011	7						L ROA				
-	11.K	toll for	JZL	_		SAL	ISBUR	Y, M	IARYLA	ND 2	1801	410)-742-5141
- 1	23 PARY I. Enter the diseases, or c shock, or heart failure. I	omplications that co	used the de	eth. Do n	ot anter th	a mod	le of dying	, such	as cardiac	or respir	atory arr	est,	Approximate
- 1	IMMEDIATE CAUSE (Final	int biny ona cause											Interval Between Onset and Death
1		ACU	Te 1	MALE	CAL	20	20	. ~=	ARCI	70N	ANT)	IDAV
ľ	teaditing in death)	DUE TO (QF	AS A CONSE	OUENOE OF):		A	00	Hu7	70 m	ia	_	12.7
z					MO CARDIAL INFARCTION AND IK						i i		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSE	QUENCE OF	7):								+
3	cause. Enter UNDERLYING	A72	bro_S	cles	2050.	5							
Ė	CAUSE (Disease or injury that initiated events		AS A CONSE										
ᇤ	resulting in death) LAST	My	2nt es	vsu	o An	0	2	156	1010	De M	11		
- 11	DAOT II Other significant condition												
EDICAL	PART II. Other aignificant conditions		ith but not r	reaulting i	n tha unde	rlying	cause giv	en in Pa	irt i. 24a	PERFORI			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ăI	- MYNAW	Cep/	ge						_ 10	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
M													1 TYES 2 NO
	DID TOBACCO USE CONTR	BUTE TO CAUS	E OF DEA	TH YE	S I NO	D E	UNCER	RTAIN					
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				H (Check only								
š	1 TES 2 NO	HOSPITAL:	/Outpatient 3	□ DOA	OTHER:	a Home	5 D Reald	lence 6	☐ Other (Spi	ac/h/)			
È	27. MANNER OF DEATH	26a. DATE OF INJ	URY	26b. TIME	OF 28	c. INJU	RY AT		8d. DESCRIB		JURY OCC	URED	
_	1 Netural 5 Pending	(Month, Day,)	bar)	JUNI		WOR	K? ES 2	NQ					
à	a □ estate —	28e. PLACE OF IN	JURY At ho	me, farm, s	treet, tectory	office		2	81. LOCATION	N (Street at	d Number	or Rumi Bo	uta Number
		(Specify)		•				City or Tov	vn, State)		0. / 18/18/11/0	ore remove,	
	4 Homicide 6 Could not be												
LETED	4 Homicide determined							nd dies de	the course(s)	and many			
MPLETED	4 Homicide determined 29a. CERTIFIER (Check only)	TAN: To the bast of my											
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER												end menner ee stated.
E COMPLETE	4 Homicide determined 29a. CERTIFIER (Check only)	l: On the basis of exami	nation end/or i			ilon, de		at the tin	ne, date and		due to the	ceuse(a)	end menner ee stated. Month, Day, Year)
BE COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 20c. CERTIFIER OF CERTIFIER 20c. CERTIFIER OF CERTIFIER	t: On the basis of exemi	nation end/or i	Investigation	n, In my opin	ilon, de	eth occured	at the tin	ne, date and		due to the	ceuse(a)	
E COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	t: On the basis of exemi	nation end/or i	Investigetion	n, In my opin	ilon, des	29c. LICENS	st the tin	ne, date and ER	place, and	due to the	SIQNED (Month, Day, Year)
BE COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	nation end/or i	Investigetion	n, In my opin	ilon, des	29c. LICENS	st the tin	ne, date and ER	place, and	due to the	SIQNED (Month, Day, Year)
BE COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 20c. CERTIFIER OF CERTIFIER 20c. CERTIFIER OF CERTIFIER	COMPLETED CAUSE OF	F DEATH (ITE	W 27) (Type,	Print)	ilon, des	29c. LICENS	st the tin	ne, date and ER	place, and	due to the	SIQNED (



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be followed by the following the fo
INT CHINAL II HEIN CA IS HIGHER OF HEIN CA SHOWS SHIP IN CHIE HEMISTER CASHING HISTORY OF HOUSE OF THE STATE

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND) / DEPARTI				HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				DEATT	2. DATE OF	DEATH		3. TIME OF DEATH	
	Barbara	Marie Eaton				Senter	nber 25.	1 QQ5	9:57 A M	
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH	6. BIRTH	IPLACE (State or Foreign	
	217–12–4503 19a. FACILITY NAME (If not institution, give stree	□ M 2 L F 7.	1 YRS.	ONTHE DAYS	HOURS MM.	June 21	, 1924		yland	
R	12400 Ridgely Road	e and number)	91	Rido	R LOCATION DF	DEATN		OUNTY OF D		
5	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY						1.0	aroli	ne	
DIRECTOR			10c. CITY, T	OWN DR LOCAT	ION		10d. INSIDE CITY LIMITS?			
	Maryland Oueen	Anne's	O ₁	ieen An	ne ZIP CODE		10.0		1 LYES 2 NO	
RA	First Street			100	777-175		10g. C		YHAT COUNTRY?	
FUNERAL		2. WAS DECEDENT EVER IN U.S.		13. WAS DEC	21657 ENDENT OF HISP	ANIC DRIGIN? (5	specify Yea or No-		S.A.	
	1 Never Married 2 Married	Married FDRCES? 1 YES 2 X NO			cify Cuban, Mexi-	can, Puerto Rica		Black Speci	American Indian, c, White, etc.	
Э ВУ	3 Widowed 4 Divorced				74				asian	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working						ND OF BUSINESS/I	NDUSTRY		
J.E	11 HS grad.	College (1-4 or 5+)	Ille. Do NOT use re	,						
ME	17. FATHER'S NAME (First, Middle, Last)		Homen	naker	40 1007117010		Home			
	James Ear	Walters					lie, Maiden Surname			
BE	19a. INFORMANT'S NAME (Type/Print)	Marcers	19b. MAILING AD	DRESS (Street a			deline City or Town, State,			
9	Linda Gleaton				ueen An			21657		
	20g METHOD OF DISPOSITION 1 2 Burial 2 Cremation 3 Remove	20b. PLA	CEANDDATEDE	SPOSITION (Na		OATE	20c. LOCATION -		wn, Stata	
х Л	4 Donation 5 Other (Specify)		eremetory or other	Cemete	ry	9/28	Hillsbo	oro.	Maryland	
	21. BIGHAPTIRE OF FUNERAL SERVICE LICEN	". 1 M			D ADDRESS OF					
	(Kaudab	u P.116	ore		e Funer				0.000	
	23. PART I, Error the diseases or con	nplications that ceused tha	deeth. Do not	entar the mo	de of dying, au	ich aa cardiec	or respiratory	rrest,	Approximata	
	iMMEDIATE CAUSE (Final	t only one cause on each i	ine.						Interval Batween Onset and Death	
	disease or condition resulting in death) a. Obstructive Pulmonary dis & emphysema Due to (or as a consequence of)									
				4	7 , 4			7		
8	Sequentially list conditions, Due to (or As a consequence or): Due to (or As a consequence or):									
E	and the state of t									
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEDUENCE OF):	Edif	131	ILIE				
CERTIFICATION	reaulting in death) LAST				0					
	PART II. Other algnificant conditions of		A 101 1							
B	PART II. Other aignineant conditions of	ontributing to death but no	ot resulting in t	ne underlying	cause given i	n Part I. 24	PERFORMEO?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ED						11	YES 2 NO		OF DEATH?	
Σ									1 TES 2 ND	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (C	hack nak one)				
SIC	4 🖂 1950 - 4 🖂 195	IOSPITAL:		THER:	5 - Residence					
Ŧ	27, MANNER OF DEATN	28e. DATE OF INJURY	28b. TIME O	F 28c. INJU	IRY AT		BE HOW INJURY O	CCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		RK? ES 2 ND					
	3 Sulcide 6 Could not be	28e. PLACE OF INJURY — At building, etc. (Specify)	home, farm, stree	et, factory, office		26f. LOCATIO	N (Street and Numb	er or Rural R	oute Number,	
	4 Homicide determined					Only or R	Wil, State)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowledge,	death occurred a	t the time, date	and place, and du	e to the cause(s	and manner as st	inted.		
8		On the beals of examination and/							and manner as stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	, V .		T	29c. LICENSE NO		29d. DA	TE SIGNED	(Month, Day, Year)	
TO B	× 65.71	H			D 475	34	P S	ept. 26	, 1995	
F	30. NAME AND ADDRESS OF PERSON WHO C							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Wafik Zaki, M.D.,	PO Box 496, D	enton,	Marylar	nd 2162	29				
	31. DATE FILEO (Month, Day, Year) SEP 27 '95	32. REGISTRAR'S SIGNATURE								
	SET 6 1 99	a Navidson-Ra	ndelle							



B.K.S

95-242 ITEMS: 23 PART I, 27, 28a-f, PER MED FILM G-728 10/20/95 t.t

95 31245

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1, DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR ALLEN EYLER SEPT. 30 1995 ERIC 1305 M P 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS HOURS 33 MONTHS 1 X M 2 F 215-64-2112 962 Feb. 15, Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WOODSBORO FREDERICK DIRECTOR 11901 WHISKEY SPRINGS ROAD RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Carrol1 1 YES 2XXNO Union Bridge permit. FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 12028 Coppermine burial-transit Road 21791 United States retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, alc. It yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 VES 2 NO Specify: FORCES? 1 YES 2 NO XX Never Married 2 5 Married В 3 Widowed 4 Divorced White 部 93 50 15. DECEDENT'S EDUCATION 18a. OECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY nse (Specify only highe (Give kind of work done ife. Do NOT use retired.) Щ College (1-4 or 5+) Po Elementary/Secondary (0-12) Truck Driver COMPL Trouts Supreme Seafood 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maider Sumeme) Ħ Roger Atvill Eyler Shirley Ann Shoemaker BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Edward S. Eyler 500B Heather Ridge Drive Frederick, MD 21702 page after death. Page 6 may be pe 20a, METHOD OF OISPOSITION
1 N Burlai 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must director, Glade Cemetery 10/5/95 Walkersville, Maryland 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE, funeral 240 40 Fulton Ave. Walkersville, MD 21793 filled in by the on, or removal. the medical 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between 6 Onset and Death IMMEDIATE CAUSE (Final the cremation, disesse or condition COCAINE INTOXICATION reaulting in deeth) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 If any, lesding to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL 可見 any COMPLETION OF CAUSE signed t YES 2 NO OF DEATH? shows 1 YES 2 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 26. PLACE OF OEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL certificate h the State 1, or Item HOSPITAL OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA X XYES 2 NO WOODS 4 Nursing Home 5 Reeldence (XX) ther (Specify) 27. MANNER OF DEATH 28a OATE OF INJURY 284 DESCRIBE HOW INJURY OCCURED 26b. TIME OF 28c. INJURY AT WORK? this c marked. 1 Natural 5 Pending FOUND 9-30-95 1 YES 2 XXNO UNKNOWN UNKNOWN BY Investigation After 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Flural Route Number, City or Town, State) 11901 WHISKEY SPRINGS 3 Suicide 8XX Could not be datermined 00 DIRECTOR: A hours after d item 28 is COMPLETED 4 Homicide FOUND IN WOODS WOODSBORO, MD. RD. 29s. CERTIFIER

(Chack only.)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated FUNERAL I within 72 h HOSPITAL XX MEDICAL EXAMENER: On the beets of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: III 296. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d DATE SIGNED (Month Day Year) BE ▶OCT. 1,1995 O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

LOCKEIM

1995

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32. REGISTRAR'S SIGNATURE

Muchen Ran

Aron

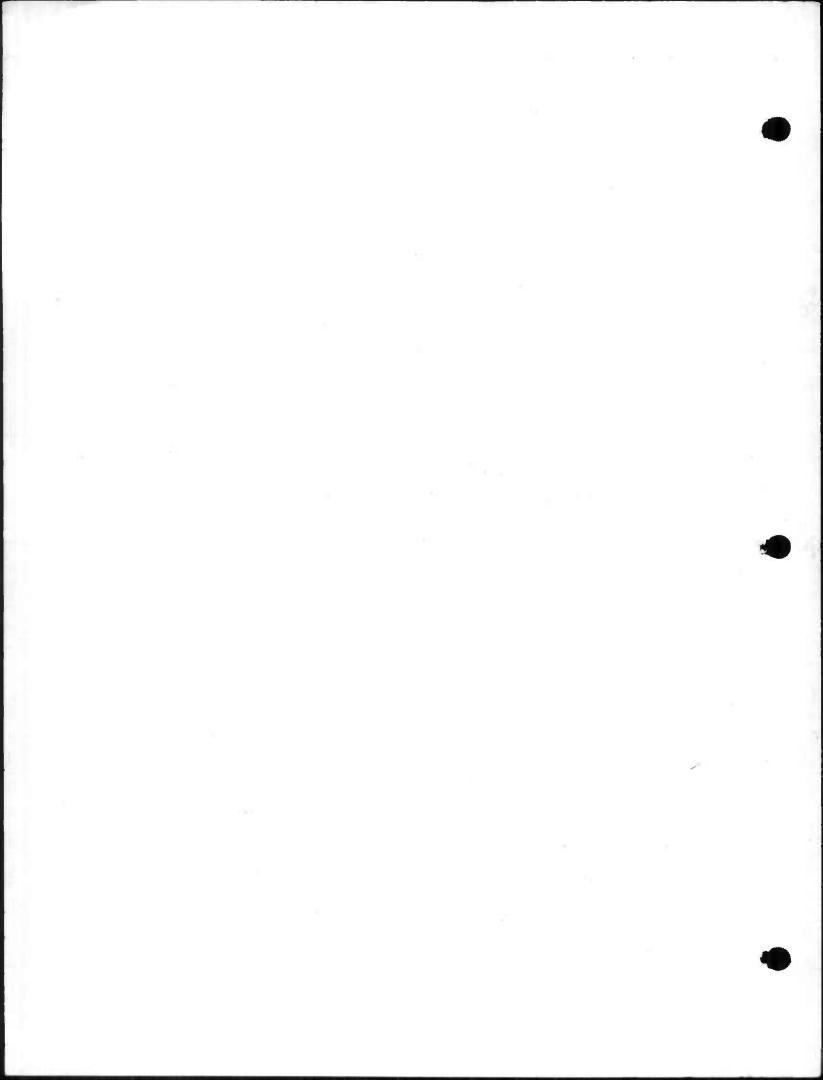
06

31. DATE FILED (Month, Day, Year)

BALTIMORE, MARYLAND 21215-0020 6876 RECORDS, P.O. BOX DIVISION OF VITAL

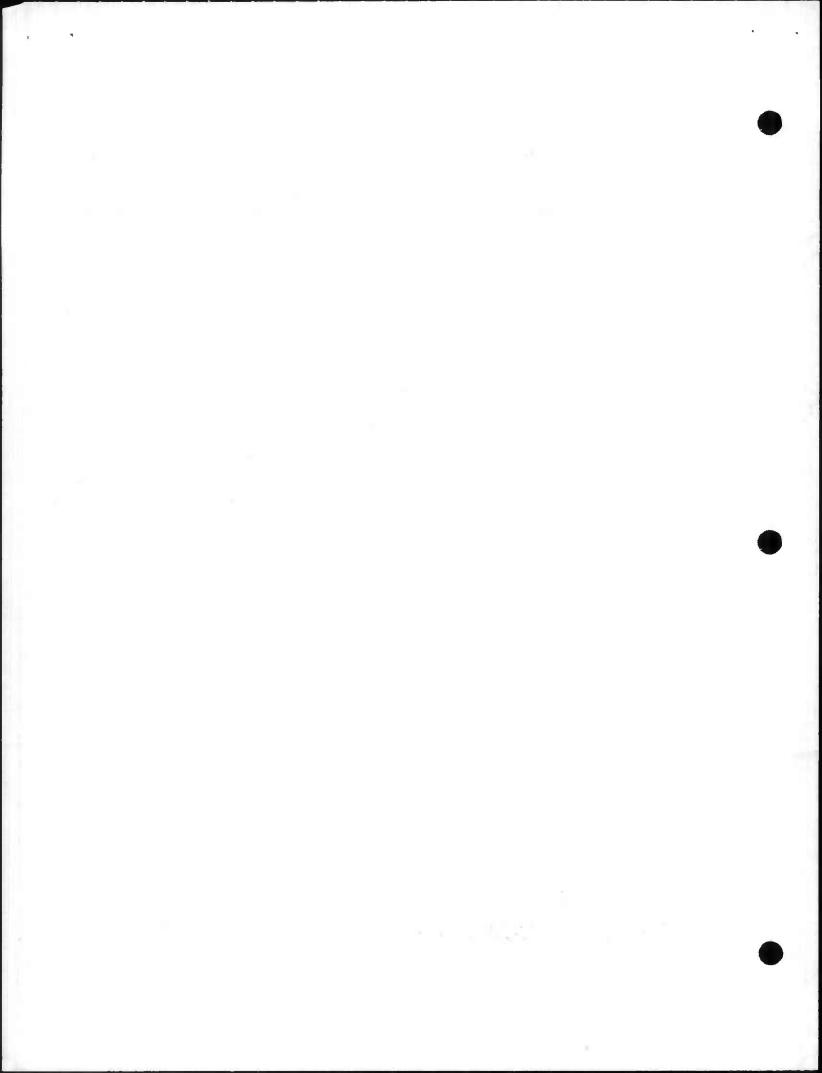
executed certificate be the death requires that DR ATTENDING PHYSICIAN: The law

111 Penn Street, Baltimore, Maryland 21201



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		IENT OF HEALT		AL HYGIENE REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)				2, DAT	E OF DEATN		3. TIME OF QEATN	
1 3	HOWARD	E. Gu	THRIF		SE !		1995	9:05 AM	
1 8	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UND	ER 24 HRS. 7. DATE	OF BIRTN	8. BIRT	NPLACE (State or Foreign	
	579-16-7593 Sa. FACILITY NAME (If not institution, give s		2 YRS.	MONTHS DAYS HOURS MIN. (Month, Day, Year) Nov. 15, 1902 Virginia					
E C				CITY, TOWN OR LOCA		1	9c. COUNTY OF	tgomery	
DIRECTOR	Washington Adversibence of Decedent 10a. STATE 10b. COUNT			OWN OR LOCATION	IULK			10d. INSIDE CITY	
	Maryland Dorchester			ishing (Creek			LIMITS?	
FUNERAL	100. STREET AND NUMBER 1125 Keys Road	đ		101. ZIP CO	1634	1	10g. CITIZEN OF	WHAT COUNTRY?	
ž.	11. MARITAL STATUS	12. WAS OECEDENT EVER IN	U.S. ARMED	13. WAS DECENOENT		N2 (Specify Years)		E — American Indian,	
	1 Never Married 2 Married	FORCES? 1 YES	2X NO	If yes, specify Cu	ban, Maxican, Puarto	Rican, etc.)	Blac	ck, White, etc.	
ВУ	3 X Widowed 4 Divorced	IF TES, GIVE WAR ON ON	ies	1 - YES 2 XN	O Specify:		Spec	White	
TED	15. OECEDENT'S EOU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USL (Give kind of work	done during most of wor	rking 16	b. KIND OF BUSIN	ESS/INDUSTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use re	,		n a			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Cabinet		TNER'S NAME (First,		lucatio	on	
BE	William James	Bolling Gu	thrie		Nancy Hu	ddlest	on		
10	100. INFORMANT'S NAME (Type/Print) Blanche Thomps	FOR	9504 T	PRESS (Street and Number	Der or Rural Route Num	TIPPOS	State, Zip Code)	20772	
	204 METHOD OF DISPOSITION		PLACE AND DATE OF D						
	1X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from Stala come	etery, crematory or other	placel	1		TION — City or T		
1 3	21. SIGNATURE OF FUNERAL SERVICE AS	ENSEE	rchester	Mem. Pa	RESS OF FACILITY	-3 Call	priage	e, MD.	
	> HOPPORT HA	wad for		Curran-E					
	23. PART I. Enter the diseases, or	complications that caused	the death. Do not	308 High	St., C	ambrid	ige, Mi	21613 Approximate	
	ahock, or heert failure. IMMEDIATE CAUSE (Final	List only one ceuse on ea	ch line.	one the mode of a	rying, addir aa cor	diec of respitat	tory arrest,	interval Between Onset and Death	
	Parallel Communication of the	e. SEVERE DUE TO (OR AS A	HYPOX	EMIA	AND H	100UFUT	THATE		
						11 0000	, , , , ,	6 1000	
NO.	Sequentially list conditions,		CONSEQUENCE OF):	CTIC ANE	URISM			3 days	
₽¥.	If any, leading to immediate cause. Enter UNDERLYING	•							
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				-		
CERTIFICATION	resulting in death) LAST	d							
AL C	PART II. Other algnificent condition		it not resulting in th	ne underlying couse	given in Part i.	24a. WAS AN AU		b. WERE AUTOPSY FINDINGS	
15	ABDOMINAL	ANEURISM				PERFORME		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	BOWEL OB	STRUCTION	/					OF DEATH?	
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES	□ NO 🖾 UN	CERTAIN				
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		8. PLACE OF DEATH (C			9			
Š	1 ☐ YES 2 M NO	HOSPITAL; 1 Inpatient 2 ER/Outpe		HER: Nursing Nome 5	Residence 6 🗆 Othe	er (Specify)			
PHYSICIAN	27. MANNER OF DEATN	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	26d. DE	SCRIBE HOW INJU	JRY OCCURED		
₩	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2	□ NO				
G	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, atc. (Specif	— At home, lerm, stree (y)	t, lectory, office	281, LOC City	CATION (Street and or Town, State)	Number or Rural	Route Number,	
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
COMPLET		R: On the basis of examination						si and manner se stated	
	29b. SIGNATURE AND TITLE OF CERTIFIER								
BE (R, 1	MD			23177	2	▶ 9/2	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH						1/2	1/	
	MARIO O. BE	LLEDONNE	- , 12	1 CONG	RESSION	IAZ WA	WE £	\$205 ROCK.	
	31. DATE FILED (Month Pary Harl) QC	2. REGISTBAR'S, SIGNA							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

	REGISTRAN			ENTIF	CATE	OF	DEAL	П	н	EG. NO.			
i	1. DECEDENT'S NAME (First, Middle, Last) DELORES	1	BYK		GILI	RERT	r		2. DATE OF C MONTH Septem	D43	, 1 1995	YEAR	3:30 a M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	at hirthday	IF UNDER 1		IF UNDER	A4 MING	7. DATE OF B		1,1775		LACE (State or Foreign
	173-26-7334	1 □ M 2 X F	63	YRS.		DAYS	HOURS	MIN.	November	y, Yber)	31	Country)	sylvania
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, T	OWN OF	R LOCATIO			2,13		TY OF DEA	
<u> </u>	23451 Deal Island					ance					Sc	mers	ot
2	RESIDENCE OF DECEDENT	u.			Olife							mer 3	e c
<u> </u>	10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN OR	LOCATI	ON					1	IOd. INSIDE CITY
DIRECTOR		merset		Cl	nance								LIMITS?
₹	10e. STREET AND NUMBER					101.	ZIP CODE						IAT COUNTRY?
<u> </u>	23451 Deal Island	d Rd.					218	316				USA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A		13, W	AS DECE	NDENT OF	F HISPAN	NIC ORIGIN? (S	pecify Yea	or No-	14. RACE -	- American Indian, White, atc.
8	1 Never Married 2 Married	IF YES, GIVE V		NO			2 NO			i, ett.;	- 1	Specify	
	3 Widowed 4 Divorced											Whi	te
3	15. DECEDENT'S EDUC (Specify only highest grade		16a. D	ECEDENT'S	USUAL OCC	UPATIO	N Laf working	7	18b. KIN	D OF BUS	NESS/IND	USTRY	
4	Elementary/Secondary (0-12)	College (1-4 or 5	- 10	le. Do NOT us	se retired.)	ang mou							
፤	12		H	Homema	aker								
COMPLEI	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, Middle	e, Maiden S	iumame)		
	Harry Patrick	Smith					Emn	neli	ne Gr	ace	Grif	fith	
מ	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS /	Street an			Route Number, C				
2	Davis Gilbert								., Cha				
	20a. METHOD OF DISPOSITION		205 01 405		OF DISPOSIT				DATE			City or Tow	n State
	1 Buriel 2 Cremetion 3 Remo	oval trom State			therplace)				9/21			ury,	
- 1	4 Donation 5 Other (Specify)	eutee	Joanna	sbury			D ADDRES	C OF FA		06	11130	dry,	HD
	21. SIGNALUM GATTERAL SENVICE LIC	100			22. N	lo11	oway	Fur	neral E	Iome			
	WON KH	00 601	ru-	-							isbu	rv. M	ID 21801
CERTIFICATION	shock, or heert fellure. IRMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentielly list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	DUE TO	(OR AS A CONSI	EQUENCE O	F): F):	(Com	u					Interval Between Onset and Daath Ay/ S
H	resulting in deeth) LAST	d											
	PART ii. Other algoliticant condition	e contributing to	death but not	regulting	In the und	echilog	COURA	lven in	Part I 24	. WAS AN	MITTOREY	245 1	WERE AUTOPSY FINDINGS
MEDICAL							30000		1 {	PERTORI	MEO?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CA			S 🗆 N		LUNC	ERTAI	Ν□				
5	25. WAS CASE REFERRED TO MEDICAL	HOSBITAL	28. PL/	ACE OF DEA	TH (Check on								
2	1 TES HO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	: ng Home	5 X Re	aldence	6 Other (Sp	secify)			
РНҮ	27. MANNER OF DEATH	28a. DATE OI (Month, I		28b. TIM	IE OF 2	28c. iNJU			28d. DEŞCRI	BE HOW IN	JURY OC	CURED	
-	Hamural 5 Pending investigation	[Month, a	vay, roury	1	M	1 🗌 Y		NO					
2	2 C Accident		OF INJURY — At t	home, term,	street, tactor	ry, office	1		281. LOCATIO		nd Number	or Rural Ro	oute Number,
ED	6 Could not be determined	building	, atc. (Specify)						City or To	wn, State)			
4	29a. CERTIFIER								and area				
COMPLET	(Check only	CIAN: To the best o											
2	2 MEDICAL EXAMINE	H: Un the beals of a	A and/o	r investigatio	on, in my op	inion, de	eath occur	ed at the	time, data and	place, and	due to th	e cause(a)	and manner as stated.
BE C	295. SIGNATURE AND TITLE OF CERTIFIE		111	111			29c. LICE	NSE NU	MBER		29d. DAT	E SIGNED (Month, Day, Year)
	100 ×	-00					02	62	78		> 9	7-21	-15
0	30. NAME AND ADDRESS OF PERSON WHO	MD /4	_	EM 27) (Type	11 0	7.	5	olis	4,	MD	218	F 6 1	
	SEP 25 199	32. RHGISTR	AB'S SIGNATURE	0 ,,					0		_		
- 1	I 22 122	JIMA	M. MANAMAN M.	work									

L OR ATTENDING PHY	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	Prours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PH	THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death wi	IMPORTANT: If item 28 is marked,

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
	CE	ERTIFICATE	01	F DEAT	TH		REG. NO.

1	FOR STATE OF STATE OF	MARYLAND / DEPA	RTMENT OF I		MENTAL HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Last) VENNIE T. GL	ADDEN	J		2. DATE OF DEATH DAY	95	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 219-14-4697 So. FACILITY NAME (If not institution, give street end number)	6. AGE (In yrs. lest birthday. 70 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 3-17-1925	Count	a BIRTNPLACE (State or Foreign Country) Maryland			
	University Hospital		100	imore (
	Md .		altimor				10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
	10e. STREET AND NUMBER			r. ZIP CODE			WHAT COUNTRY?			
FUNERAL	206 Furrow St. 11. MARITAL STATUS 12. WAS DECEDE	INT EVER IN U.S. ARMED	12 MM C DE	21223	NIC ORIGIN? (Specify Yee or	U.S.	A . E American Indian,			
B	1 Never Narried 2 Married FORCES?	1 X YES 2 NO WAR OR OATES WW II	It yes, s		in, Puerto Rican, etc.)	Spec	k, White, etc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or	(Give kind o	'S USUAL OCCUPATI If work done during m use retired.)		166. KIND OF BUSIN	IESS/INDUSTRY				
Ĭ.	8	Sales	man			sh Mar	ket			
	17. FATHER'S NAME (First, Middle, Last) Marvin Gladden			Agnes	AME (First, Middle, Malden Su	irname)				
H -	19e. INFORMANT'S NAME (Type/Print)	19b. MAILR	G ADDRESS (Street		Route Number, City or Town,	State, Zip Code)				
2	Marion Gladden	Box	362 F	ruitlar	nd, Md 218	26				
- 1	20a. METNOD OF DISPOSITION 1 Description Burlel Cremetion Bernoval from State	20b. PLACE AND DAT cametery, crematory of			OATE 200. LOCA	TION — City or T				
- 11-	4 Dunismon Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Springh		NO ADDRESS OF FA		ron, r	id.			
	Quald & Sou	nex	Bour	ds Fune	eral Home,	Salis	bury, Md.			
CERTIFICATION	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) A VENTRICULAR TACHYCARD A DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
A I	PART II. Other algnificant conditions contributing	UTOPSY 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
Z	DID TOBACCO USE CONTRIBUTE TO C				Ν□					
200	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 inpetient 2	V V	OTHER:		8					
0	27. MANNER OF OEATN 28e. DATE (Month	OF INJURY 28b. 1	IME OF 28c. IN	IJURY AT YORK?	6 Other (Specify) 28d. DESCRIBE NOW IN.	JURY OCCURED				
TED BY	3 Suicide 28e. PLACE	OF INJURY — At home, ferring, atc. (Specify)	n, street, factory, off	Ice	281, LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	29e. CERTIFIER (Check only one) t CERTIFYING PHYSICIAN: To the best one) 2 MEDICAL EXAMINER: On the best of						(e) end manner ee stated.			
O BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED C.	AUSE OF OFATN LITEM 27 /X	roe. Print	29c. LICENSE NU D3 19	93		O (Month, Day, Year)			
	THE REPORTED OF PERIOD THE COMPLETED OF		proof 4 Friedly							
	SEP 22 1995	Davideor Randell								



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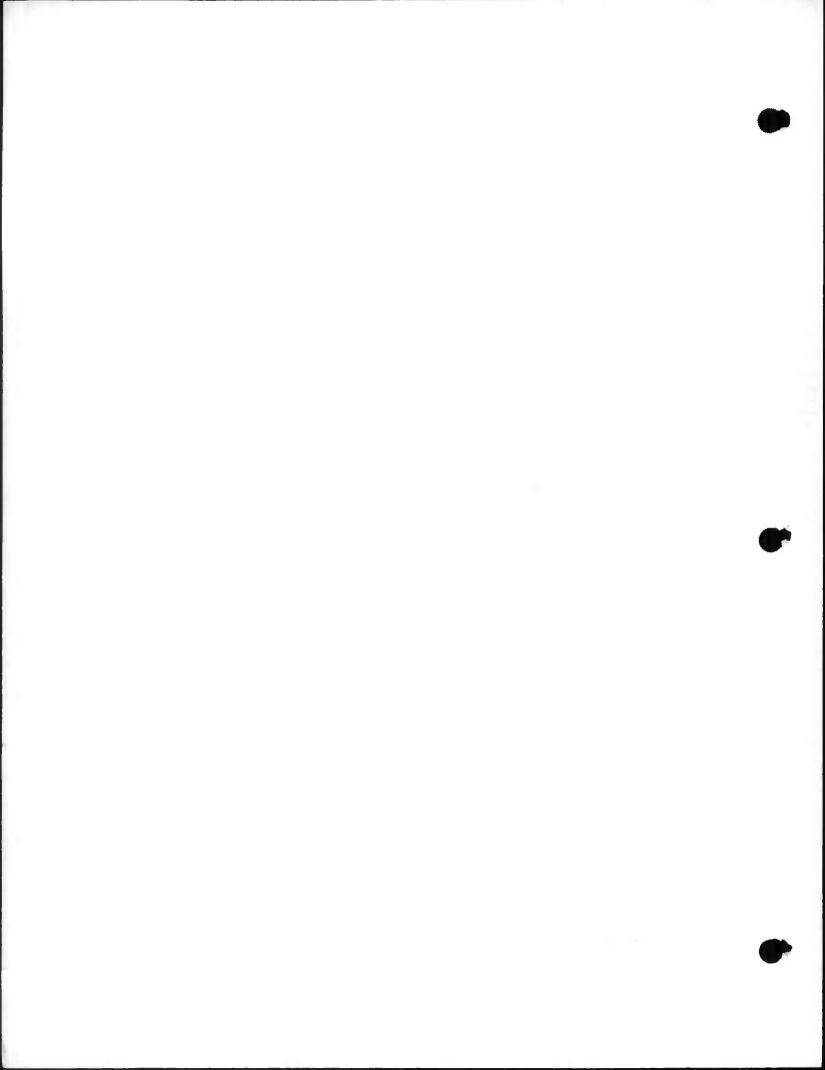
Section 4 DE april 19

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	HEGISTRAH			EHILL	ICALE	OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Fannie Laverta	GOODWIN					2. D/ SMC	Sept. 26, 1995 YEAR 9:30				
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. les		IF UNDER 1			7. D/	7. DATE OF BIRTH			IPLACE (State or Foreign
	434-54-2267	1 🗆 M 2 📉 F	87	YRS.	MONTHS	DAYS	HOURS MIN.	Mar	ch 3, 190	8	Loui	Siana
	9a. FACILITY NAME (If not institution, give s				9b. CITY,	TOWN (OR LOCATION OF I				NTY OF D	EATH
S S	7046 Catalpa F		F	rede	erick			F	redei	rick		
ן מ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	v		T			urasu -					
E	Maryland Frede				y, town of ederi		ION					10d. INSIDE CITY LIMITS?
7	10e. STREET AND NUMBER	LICK		I II	eder.		. ZIP CODE			40. 017		1 TYES 2 X NO
FUNERAL DIRECTOR	7046 Catalpa Ro	ad				101	21701				J.S.A	
5	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS OECEDENT FORCES? 1	EVER IN U.S. AF	RMED			ENDENT OF HISPA			or No-	14. RACI	E — American Indian, k, White, atc.
B	3XXWIdowed 4 Divorced	IF YES, GIVE W	AR OR DATES				2 NO Spec		no rican, atc.)			"y: White
	15. DECEDENT'S EDUI		16e. DE	ECEDENT'S	USUAL OCC	CUPATIO	ON st of working		16b. KIND OF BUS	INESS/INE	DUSTRY	
COMPLETED	Elemantary/Secondary (0-12)	College (1-4 or 5+	life	. Do NOT us	e retired.) nemake		or or or or or or		Own	Home	9	
O.	17. FATHER'S NAME (First, Middle, Last)			-			18. MOTHER'S N	AME (Fin	st, Middle, Meiden	Sumame)		
BE C	Jefferson		KENNED				Sarah	ı E	mily WA	ARNEI		
10	190. INFORMANT'S NAME (TyperPrint) Mrs. Barbara G. S		19	13539	John	(Street e	nd Number or Rure Line Roa	id,	umber, City or Town Smithsbu	i, State, Zip 1rg,	Md.	21783
	20s METHOO OF DISPOSITION 1 Description SUPPLIES 4 Donation 5 Other (Specify)	cometery, cre New Po	CEANDDATE of DISPOSITION (Name of parties) Palestine Cemetery, Sept. 29, 1995 Picayune, Mississippi								wn, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC	22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home								L Home		
	23. PART I. Enter the diseases, or o	complications that	MOO2		100	o Ea	ast Chur	cch	St., Fre	ederi	ick,	
ĺ	shock, or heart failure.	List only one caus	se on aach iins	1. DO 1	iot airtar ti	na mo	da or dying, su	en as e	ardiac or respii	atory an	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition									Onset and Death		
	DUE TO (OR AS A CONSEQUENCE OF):										391.	
z	DI ARFTEL											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
2	CAUSE (Disease or Injury C. OUE TO (OR AS A CONSEQUENCE OF):											
	that initiated avents resulting in death) LAST	OUE TO (OR AS A CONSEC	QUENCE OF	7):							
<u>ا يا</u>	d.											
	PART II. Other significant condition	s contributing to	death but not r	resulting I	n the und	erlying	cause givan ir	Part I.	24a, WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL						_			PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 - 4			OF DEATH? 1 YES 2 NO
ä	DID TOBACCO USE CONTE	RIBUTE TO CAL	JSE OF DEA	TH YE	S 🗆 N	0 🗆	UNCERTAI	IN 🗆				
중	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
YSI	1 TYES 2 NO	1 Inpetient 2	ER/Outpatient 3	□ DOA	OTHER:		5 Residence	6 □ 0	ther (Specify)			
BY PHYSICIAN: M	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF I (Month, Day	NJURY V. Year)	28b. TIMI INJ		8c. INJU WOI 1 Y		28d. [DESCRIBE HOW IN	JURY OC	CUREO	
	3 Suicide 8 Could not be determined	INJURY At ho tc. (Specify)						28t. LOCATION (Street end Number or Rural Route Number, City or Town, State)				
9	29a. CERTIFIER	-	A								-	
COMPLET	(Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE	CIAN: To the best of sea	and the same of				end piece, and du eath occured at the) end manner ea stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NU	IMBER		(Month, Day, Year)		
		1/	Un	di			D 3191	.2		> 9	Sept.	26, 1995
일	30. NAME AND ADDRESS OF PERSON WHO											
	Dr. Julio Menoc	al MD 1	0po	ssumt	own I	rike	e, Frede	eric	k, Maryl	Land	2170)2
	31. DATE FILED (Month, Day, Year) SEP 2 9 1995	32. REGISTRAR	'S SIGNATURE	10								
				CO a II								



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

	1. DECEDENT'S NAME (Fi	rst, Middle, Last)								2. DATE OF			VEAR	3. TIME OF DEATH
	EMERSON		FRANI	KLIN				HENE	RY	SEPT		7 1	995	1540 P M
	4. SOCIAL SECURITY NU	MBER	5. SEX	6. AGE (/	In yrs. last birthd	By) IF UNDER	t YEAR	IF UNDER	MIN.	7. DATE OF (Month, D	BIRTN		8. BIRTH Count	IPLACE (State or Foreign
	213-44-0972		1)(X) M 2 □ F	50	YR	S. WONTHS	UAYS	HOURS	MIN.	March :		945		"Maryland
œ	9a. FACILITY NAME (# not			I DO	A D			OR LOCATI	ON OF DI	EATH			UNTY OF D	
6	RT. 338 AND EVERGREEN ROAD OXFORD TALBOT													
DIRECTOR	Monutand	10b. COUNT		_	10c.	CITY, TOWN C			1					10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBE		orcheste	r		Last	_	w Mar				100 0	TIZEN OF	1 TYES XX NO
ERAL	5662 Cedar		Road				"	216				tog. G	US	WHAT COOKINY?
BY FUNI	11. MARITAL STATUS 1 Never Married 2X 3 Wildowed 4 D		12. WAS DECEDE FORCES? IF YES, GIVE	1 YES	2XX NO		it yes, sp		nn, Mexica	NIC ORIGIN? (Sen, Puerto Rice		s or No-	Blac	E — American Indian, k, White, atc. Hy: White
ED	15. D	ECEDENT'S EDU	CATION completed)		16a. DECEDEN	T'S USUAL OF			na	16b. KI	ND OF BU	ISINESS/II	NOUSTRY	
PLET	Elementary/Secondary		College (1-4 or 5	i +)	Ilfe. Do NO	nan/De			-	C	offe	e Coi	mpany	
COMPL	17. FATNER'S NAME (First,	Middle, Last)			Dazeb	nan, be		7		AME (First, Mide				
l w l	Emerso		гу					Mab	el N	McCart	er			
TO B	Kitty M. H									Route Number, E. New				land 21631
	20a. METHOD OF DISPOS	SITION atlon 3 🗆 Ram	noval from State	20b	PLACEANDD	TE OF DISPOS	SITION/N	lame of		DATE	20c. L	OCATION -	- City or To	own, Steta
	4 Dorchester Memorial Park 9/30 Cambridge, Maryland										Maryland			
	Thomas Funeral Home, P.A.													
	700 Locust St. Cambridge, Maryland 21613 23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate													
ATION	shock, or heart failura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a donseouence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or in that initiated events resulting in death) L.		DUE TO	O (OR AS A	CONSEQUENC	E OF):								
EDICAL	PERFORMED? AMAIL t YES 2 \sum NO OF DI										. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO			
	DID TOBACCO	USE CONT	RIBUTE TO C	AUSE O	F DEATH	YES 🗌	NO [] UNG	CERTAI	IN 🗆				
CIA	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:		26. PLACE OF	OTHE)					~ ~ ~ ~ ~ ~	
PHYSICIAN:	1 X YES 2 ☐ NO 27. MANNER OF DEATN		1 D Inpatient 2			TIME OF		me 5 R	lesidence	8 XOther (S			SCEN	E
BY PI		Pending investigation	9 (2	Day, Year)	5 15	25 H.C	· A	YES 2 [_ NO	deceas	uch	riper	of de.	livery truck
	3 Suicide 8	Could not be determined	28e. PLACE building	OF INJURY g, atc. (Spec		rm, street, tec	tory, offi	ce			ON (Street Town, State		oer or Rural	Route Number,
COMPLETED	Anni		ER: On the basis of		rledge, death oc	curred at the t						Things South	the cause	Many land
BE C	296. SIGNATURE AND TIT	TLE OF CERTIFIE	R					29c. LIC	ENSE NU	MBER	6	29d. D	ATE SIGNE	O (Month, Day, Year)
-	Wevel	Se. 4	serg	n	10			0.	C.M	.E.		S	EPT.	28, 1995
유	30. NAME AND ADDRESS	OF PERSON WI	NO COMPLETED CA	USE OF DE	EATN (ITEM 27)	Type, Print)								
TO BE COI	271	OF PERSON WI	Kur	11		n Str	reet	t, B	alt:	imore	, Má	aryl	and.	21201

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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BALTIMORE, MARYLAND 21215-0	The other death Dane & may be redained by the bossies or secondan
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DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE MOSPITAL OR ATTRONONG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should file death with the State Dept. of Health and Mental Hydelee prior to burial, cremation, or removal.	8 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certifical be filed within 72 hours after death with the Sta	IMPORTANT: If Item 28 is marked, or ite

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

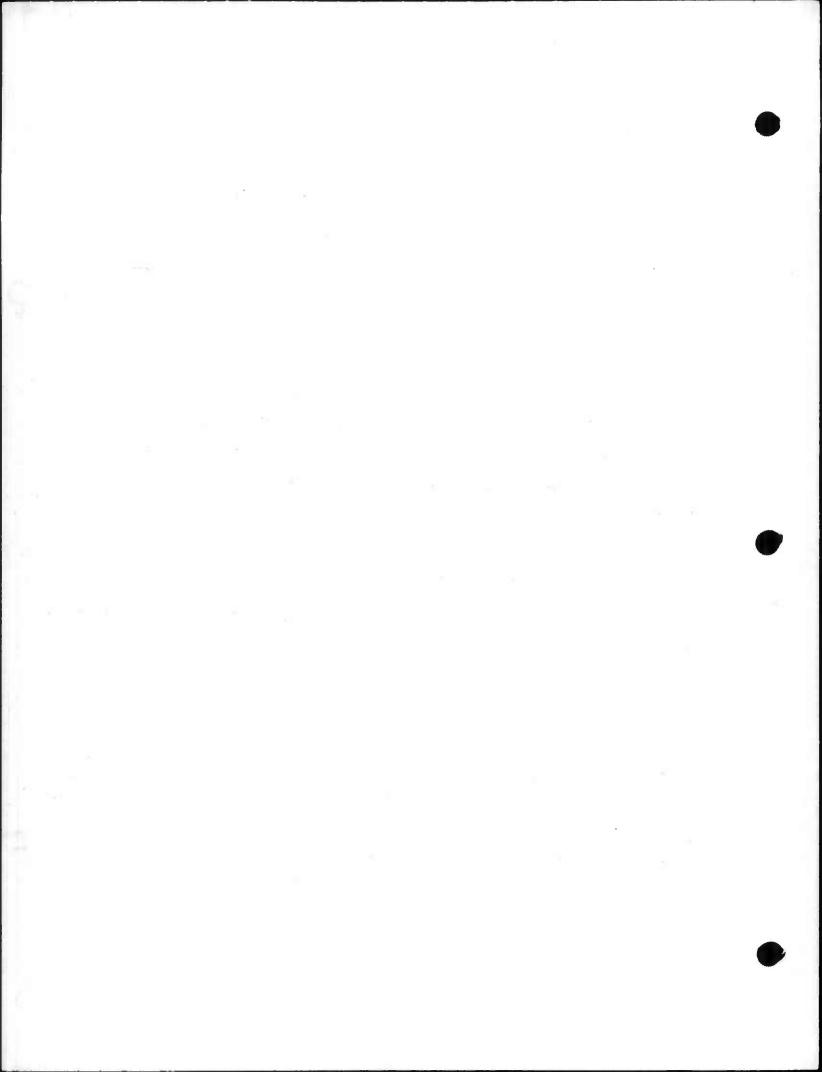
REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH

2. DATE OF DEATH

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF D	EATH .		3	. TIME OF DEATN	
	MILEY		HOLMES					MONTH DAY YEAR SEPTEMBER 25,1995 11:55P				11:55P M			
1	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDE	R 1 YEAR	YEAR IF UNDER 24 HRS.		7. DATE OF 81 (Month, Day)	IRTH			ACE (State or Foreign	
	213 - 36 - 3		1 🔀 M 2 🗆 F	58	YRS.	months.	LANTS	HOURS	merc.	May 12		37	Mary.	land	
\ m	9e. FACILITY NAME (If not in					9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	HTA	9	c. COUNT	Y OF DEA	тн	
Ē	RESIDENCE OF DEC		HOPKINS I	HOSPITAL			BAL	TIMOI	RE C	ITY					
DIRECTOR	10e. STATE	10b. COUNT	Υ		10c, CIT	TY, TOWN	OR LOCA	TION				_	1	Dd. INSIDE CITY	
E	Maryland		Cecil			E1kt	on						1	LIMITS?	
¥	10e. STREET AND NUMBER							. ZIP COD	E		10	Og. CITIZE	EN OF WH	AT COUNTRY?	
FUNERAL	36 Rock	Creek						219	21		Į	Unit	ed S	tates	
5	11. MARITAL STATUS 1 Never Married 2 🔀	Married	FORCES?	T EVER IN U.S. AR	MEO	13.	WAS DEC	ENDENT C	OF HISPAN	IIC ORIGIN? (Sp.	ecify Yee or		4. RACE -	- American Indian, White, etc.	
B	3 Widowed 4 Divo		IF YES, GIVE	MAR OR DATES			1 YES	2 🔯 NO	Specify	<i>(</i> :			Specify:	White	
0	15. DEC	EDENT'S EDU	JCATION COMPONENTS	16a. DE	CEDENT'S	USUAL C	CCUPATIO	ON		16b. KIND	OF BUSINE	ESS/INDU	STRY		
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	iii e.	f-em	se retired.)	_	st of worki	ng						
MP	12			q	ry-w	ati	cont	ract	or	New	Home	Cons	struc	ction	
	17. FATNER'S NAME (First, M.							16. MOT	HER'S NA	ME (First, Middle,			A CATT		
H	Alfred Ho							Erm	a Re	ynolds					
2			. 1							Route Number, Ch					
1	Linda Kraus		olmes	20b. PLACE						Elkton.					
	1 Burtat 2 1 Cremetlo 4 Donation 5 Dipher	n 3 🗆 Rem	noval from State	cometery, cre	natory or o	ther place	Cron	ine or	**	10/2	West	Che	ster	ylvania	
	21. SIGNATURE OF FUNERAL		CENEGE	N. M.	-	22.	NAME A	NO ADDRE	SS OF FA	CILITY			Penns	sylvania	
	1/1/	10	1/10		\leq					1 Home					
	23, PART I. Enter the di	agases, or	complications the	it caused the de	eth Do	T onto	27 S	outh	Mai	n Stree	t, No	orth	East	, MD 21901	
	snock, or no	eert fallure.	List only one cer	use on each line		not enter	i the mo	de or dy	ing, suci	n as cerulec c	or respirate	ory arrea	iit,	Approximata Interval Between	
										Onset and Death					
	disease or condition resulting in death) a. Congestive Heart Failure Due TO (OR AS/A CONSEQUENCE OF):														
Z	Ca-diomyopathy														
E	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING														
	CAUSE (Disease or Inju		C	(OR AS A CONSEC	LIENCE O	5 .			_					ļ.,	
CERTIFICATION	that initiated events resulting in death) LAS	т	-	(**************************************		,								i i	
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS														
MEDICAL	PART II. Other significe	nt condition	ns contributing to	deeth but not re	esulting	In the u	nderlyln	g cause (given in	Part I. 24s.	WAS AN AUT		All	ERE AUTOPSY FINDINGS MILABLE PRIOR TO	
Ö										1 🗆	YES 2 📆	NO		OMPLETION OF CAUSE F DEATH?	
Σ	DID TORACCO III	SE CONT	DIDLITE TO CA	HEE OF DEA	FIL M	rc ["]	NO [1 11110		. 53			1	☐ YES 2 😿 NO	
AN	DID TOBACCO U		KIBUTE TO CA		E OF DEA			UNC	EKIAI	A KA					
SIC	EXAMINER?	_	HOSPITAL:	ER/Outpatient 3		OTHE	R:	- Min							
PHYSICIAN	27. MANNER OF OEATH		28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	sidence	8 Other (Specale)		RY OCCU	RED		
ВУР		Pending Investigation	(Month, E	Pay, Year)	INJ	JURY M		RK?] NO						
	3 Suicide 8 0	Could not be	28e. PLACE C	OF INJURY At hor etc. (Specify)	ne, term,	street, tac	tory, offic	•		281. LOCATION	(Street and I	Number or	Rural Rou	le Number,	
H	4 Nomicide	Setermined		(City or Tow	n, Sielej				
COMPLETED			ICIAN: To the best of												
8	one) 2 MEOI	CAL EXAMINE	ER: On the beele of e	xamination end/or i	rvestigatio	on, In my o	opinion, d	eath occur	red at the	time, date end p	place, end du	se to the	ceuse(e) e	nd menner ee stated.	
ш	296. SHOMATURE AND TITLE	OF CENTIFIE			1 0	_		29c. LICE	ENSE NUN	IBER	29	d. DATE S	SIGNEO (M	onth, Day, Yeer)	
TO B	1/-			ساردم			4	M	1530	77		Se	ptent	0- 26,1995	
	30. NAME AND ADDRESS OF						-			43		1			
	Ja ~~ € 31. DATE FILED (Month, Day,				-4	211	> 1	tap k	-1-5	Hos	611-				
	SEP 2 8 1		4	AR'S SIGNATURE											
لب	OLF A A	111	Julia d'aveil	instructi										04444.44	
		_												OHMH-16 Rev 1/89	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

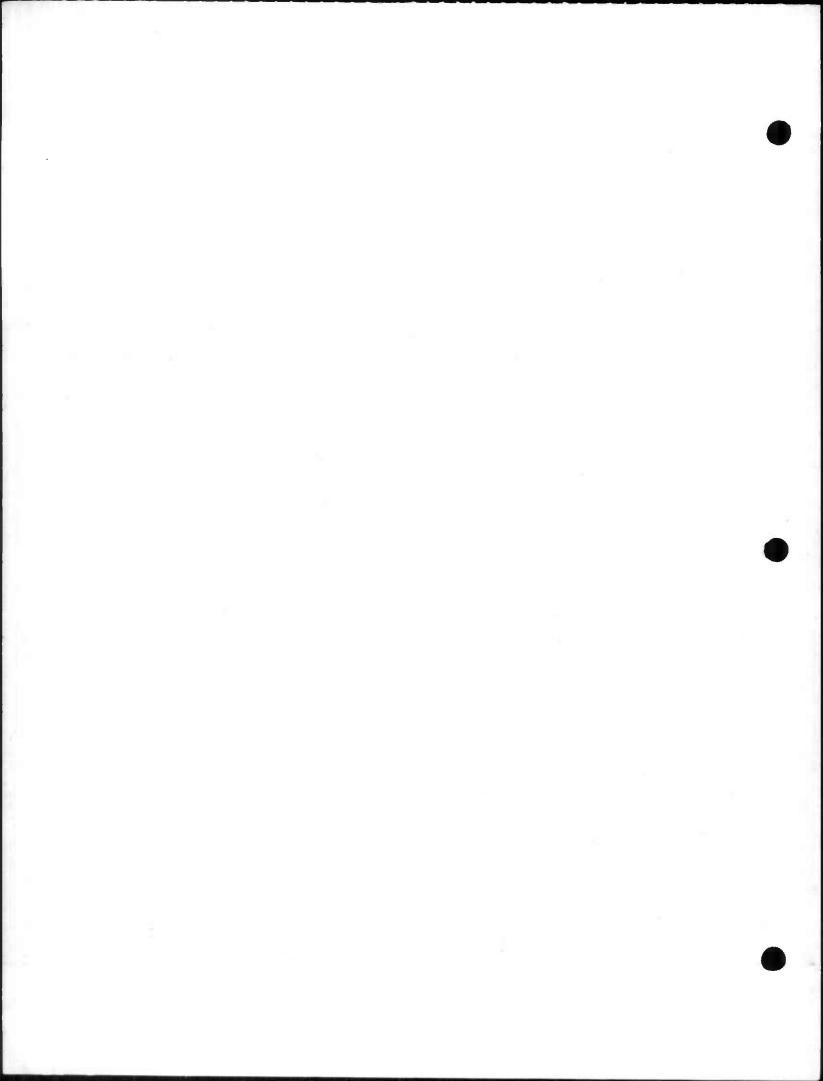
TO THE FUNERAL OHECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 STATE

	REGISTRAR		CERT	FICATE	: OF	DEATH	RE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Frederi	ck Wallac	e	Hickman			Sept. 15 1995 6:05					
		SEX 6. AG	E (In yrs. lest birtnde 70 YRS	MONTHS	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI (Month, Day, Dec.	Mari	Con	INPLACE (State or Foreign stry) ryland		
	9e. FACILITY NAME (If not institution, give stree	t and number)		9b. CITY	TOWN O	R LOCATION OF DE			COUNTY OF			
TOR	Memorial Hospital	Memorial Hospital						1	[albot			
DIRECTOR	10e, STATE 19b, COUNTY		10c.	CITY, TOWN O	R LOCAT	ION				10d. INSIDE CITY		
	Maryland Carol	ine	G	ceensb						1 YES 2 NO		
FUNERAL	P.O. Box 344					21639			U.S.A.	N OF WHAT COUNTRY?		
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 XXWidowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1 X YE IF YES, GIVE WAR OR	8 2 NO		f yes, spe	ENDENT OF NISPAN acity Cuban, Mexica 2 X NO Specify	n, Puerto Rican,			RACE — American Indian, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCAT		18e. DECEDEN				16b. KIND	OF BUSINE	SS/INDUSTRY			
COMPLETED	(Specify only highest grade coll Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	of work done of T use retired.)	unng mo:	st or working						
AP	8th		cust	odian			C	aroli	ne Cou	nty		
Š	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA			-			
BEC	Herman Hickman					Sarah V	/anSant	Hick	man			
	19e. INFORMANT'S NAME (Type/Print)					nd Number or Rural F						
2	Mary K. Hickman		31	7 Will	iams	Street	, Seaf	ord,	DE 19	973		
	20e. METNOD OF DISPOSITION 1 M Burisl 2 Cremetion 3 Ramovi 4 Donation 5 Other (Specify)	ROB, PLACE AND DA cometary, crematory Gree	TEOFDISPOS or other place) DSDOTO		oro, Maryland							
	21. SIGNATURE OF FUNEDAL SERVICE LICEN	SEE / F/	. /	F1	eeg		enbein Funeral Home					
	1 cpm	(/ru	egu			3ox 160						
	23. PART I. Enter the diseases, or cor shock, or heart fellure. Lie IMMEDIATE CAUSE (Final disease or condition recuiting in death)	Tute		lon		and c			1	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CE							-					
EDICAL	PART II. Other algnificant conditions	contributing to deat	h but not resulti	ng in the ur	nderiyin	g cause given in	Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 PMO			24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
Σ	DID TORACCO LISE CONTRI	RLITE TO CALISE	OF DEATH	VES 🗍 I	NO F	UNCERTAIL	V D			1 YES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Chock only one)											
2	EXAMINER?	HOSPITAL:	hidness a D DO	OTHE			0 0 00 (0	- 16.1				
PHYSICIAN:	27. MANNER OF DEATH	200. DATE OF INJUR (Month, Day, Yea	RY 28b.	TIME OF INJURY	26c. JNJ WO	URY AT						
ED BY	2 Accident Investigation			At home, farm, street, factory, office			YES 2 NO 281. LOCATION (Stree City or Town, State			et and Number or Rural Route Number, ite)		
ET	290. CERTIFIER						/#100 miles					
COMPLET	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my kn								e(s) and manner se stated.		
BE	296 SHIGHTTURE AND TITLE OF CERTIFIER		D 23			UMBER 29d. DATE ▶9/			ED (Month, Day, Year)			
TO	30. NAME AND ADDRESS OF PERSON WHO Stanley Bysshe, MI		DEATH (ITEM 27) (chman s		Eas	ton, MD	21601					
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S S	IGNATURE									
	SEP 1 9 '95	Julia David	lson-Randa	02								



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BALTIMORE, MARYLAND 21215-002	e hospital or attending phys
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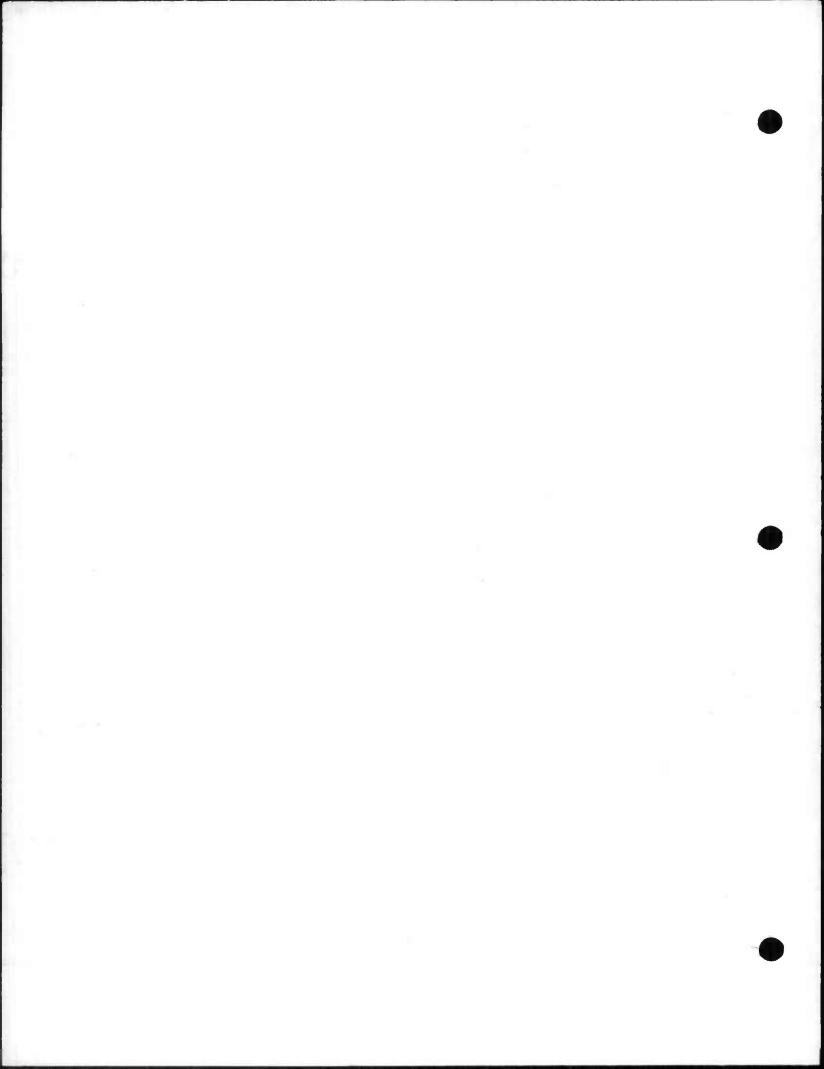
DIVISION OF VITAL RECORDS, P.O. BC

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INTENTION AND REAL OF THE PROPERTY OF STREET WASHINGTON TO STREET WASHIN	
THE CALL THE LAND OF THE ASSOCIATION OF THE THEORY OF THE THEORY STATES OF THE THEORY	

	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL	HYGIENE REG. NO.				
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH		3	. TIME OF DEATH	
	EULA M HAYMAN					09-2	27 - 95	YE	AR	1005	м
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF		8. 8	SIRTHPL Country)	ACE (State or Forei	gn
	220-32-1757 1 M 2 X F 59 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country, 98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DE									MD	_
TOR	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO										Щ
DIRECTOR	10a. STATE 10b. COUNTY 10C CITY, TOWN OR LOCATION 10									Dd. INSIDE CITY	
	100. STREET AND NUMBER	1	IIr		ZIP CODE	_		10g. CITIZEN		AT COUNTRY?	0
FUNERAL	1144 BRANT				2185	3			u.	5	
	11. MARITAL STATUS 1 2 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	13. WAS OECE If yes, spe 1 - YES	INDENT OF HISPAN city Cuban, Mexica 2 2 NO Specific	n, Puerto Ric	(Specify Yes o can, etc.)		Black, V	- American Indian, Vhita, etc.	
D BY	3 Widowed 4 Divorced								Specify:	BLACK	
TE	15. OECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEOENT'S (Give kind of w life, Do NOT us	USUAL OCCUPATION work done during mos e retired.)	N it of working	16b. K	4	NESS/INOUST			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	ABOIER			Cus	tod:			
OS	17. FATHER'S NAME (First, Middle, Last)	C-			18. MOTHER'S NA	ME (First, Mic	ldle, Maiden S	urname)			
BE	190. INFORMANT'S NAME (Type/Print)	ann JR.				enia		2200			
2	Joan E. Hayn	AA	196. MAILING	ADDRESS (Street an	Number or Flural	AVE	12,			וב מוו	83 3
	20a. METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Remo		PLACE AND OATE	F DISPOSITION (Nan		DATE	200 100	ATION — City	or Town		-
	4 Donation 5 Other (Specify)		Ohn W	Sly CE	metery	10/5/9	4 Pri	ncess	Anc	ic. MD.	
	21. SIGNATURE OF TENERAL SERVICE LICE			ANY	DADDRESS OF FA		Funcie	1 Hom	10	,	
Ш	Theolhy Co	Mu		30439	HAMPde			ncess x	nok	40.218	53
	23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, auch ea cerdiec or reapiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Onset and Death.										
	IMMEDIATE CAUSE (Fine) Onset and Death disease or condition										
	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): PERSONNEL SEASE YEARS										
NO	Sequentially list conditions,										
E	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OH AS A	CONSEQUENCE OF	·}:							- 1
빌	CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF	j):						1	
CERTIFICATION	resulting in death) LAST									ļ 	
AL C	PART II. Other significant conditions	contributing to death b	ut not reaulting 1	n the underlying	ceuse given in	Part I. 2	4a. WAS AN A			ERE AUTOPSY FIND	
MEDIC/						_ ,	PERFORM		C	MILABLE PRIOR TO DMPLETION OF CAU F DEATH?	
ME	DID TODACCO HEE	CALIFORNIA TA	011100 00							YES 2 NO	
SICIAN:	DID TOBACCO USE C	ONIKIBUTE TO	CAUSE OF		ES NO						
SICI	EXAMINER? 1 X YES 2 NO	HOSPITAL:	atient 3 DOA	OTHER:			Speciful				
РНУ	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJU	IRY AT			JURY OCCURE	D D		\neg
BY I	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆 YI	ES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	treet, factory, offica			ION (Street an Town, State)	d Number or R	ural Rou	te Number,	
,E	298. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge, death occurre	d at the time date a	and place, and due	to the cause	o(s) and meno	or so plated	_		\dashv
COMPLET		3: On the basis of axamination							use(s) a	nd manner as state	ed.
l w l	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	ABER		29d. DATE SIG	SNEO (M	lorith, Day, Year)	\dashv
0 8	John 562	7 judaden		M.E.	D03599			▶09-2	7-9	5	
[-	30. NAME AND ADDRESS OF PERSON WHO		. , , , , ,				03.05				
	JOHN T. BULKELEY, 1 31. DATE FILED (Month Ann Mon)			ROAD, S	ALISBURY	(, MD,	ST80	Τ			_
	OCT U 4. 1995"	V STATE WASHINGTON									

The second second second The limit of the state of the state of 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		A DEGERENZIO MANGES			_	CENT	IFICAL		PUEA	!П		REG. NO.			
		1. DECEDENT'S NAME (First									2. DATE OF	F DEATH DA	NY.	YEAR	3. TIME OF DEATH
		Benj	amin	Joseph	Haye	es					Septe			1995	10:53 AM
04	1 1	4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In	yrs. last birth	day) IF UNDE	III 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH		-//	PLACE (State or Foreign
		579-01-76	582	1 M 2 - F	83	YF	S. MONTHS	DAYS	HOURS	MIN.	(Month, I	24 1	011	Country	y)
Should		90. FACILITY NAME (If not in		freet and numbers	05		n. 007	V TOM	OR LOCATI			24 1		_	ryland
3 Sh	l cc	Frederick			seni	tal			rick	ON OF DE	ATH			der	
ο,	DIRECTOR	RESIDENCE OF DEC		JIIaI II	JSPI	Lai	PL	eue.	LICK				FIE	eder	ICK
×.	없	10a, STATE	10b. COUNTY	,		100	CITY, TOWN	08100	ATION						
Pages	<u>E</u>	MD					icke								10d. INSIDE CITY LIMITS?
permit.		11010001					TORE								1 YES 2 NO
	\¥	100. STREET AND NUMBER 20400 Mouth of Monocacy Rd. 101. ZIP CODE 20842 109. CITIZEN OF WHAT COUNTRY? U.S.A.										HAT COUNTRY?			
020 physician. burial-transit	FUNERAL											•			
020 physician. burial-tran	ן בָּן	11. MARITAL STATUS		12. WAS DECEDEN			13	WAS DE	ECENDENT (F HISPAN	IC ORIGIN?	(Specify Yes	or No-		- American Indien,
	BY F	1 Never Married 2 Married FORCES? 1 YES 2							S 2 NO		n, Puerto Alc	en, atc.)		Specif	, White, etc.
5-0 anding		3 Widowed 4 Divo	rced												white
	6		EDENT'S EDUC		2	18e. DECEDE	T'S USUAL O	CCUPAT	TION		16b. K	IND OF BUS	INES\$/IND	USTRY	
ND 2121 hospital or atte ached for use	E E	Elementary/Secondary (6		College (1-4 or 5 -	r)	life. Do N	OT use retired.	during n	FIUSE OF WORKI	ng					
ND hospita ached	COMPL	11				Exte	rmina	ati	on		Sel	f /A	ctic	n P	est Contro
the hor detach	ő	17. FATHER'S NAME (First, M	liddle, Last)							HER'S NAI	ME (First, Mic				obt condit
		Linwood H	Javos								Got		<i></i>		
ned by ould be	H	190. INFORMANT'S NAME (105 1444	LING ADDRES	0.00							
MAR retained 5 should notified	2					190. MAI	O M	o (Street	ena Numbel	or Hurai H	toure Number	City or Town	1, State, Zip	Code)	20842 son, MD
may be or, page		Naomi S. F								Monc					
Page 6 may be all director, page liner must be		1 Buriel 2 - Cremetic	n 3 🗆 Reme	oval from State	20b, P	PLACE AND D.	or other place	SITION (Name of		DATE	20c. LOC	CATION -	City or Tox	vn, State
Age 6 m director, or must		4 Donation 5 Other				elsvi			sbyt	eria	19/2	Ger	mant	own	. Md.
ara c		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE			22								
ALTIN death. Pag funeral di	1 1	11/m	15	1							eral				
N - 2 0		23. PART I. Enter the d	leases or o	complications the	t coursed t	the death I	20 001 001	ва	rnes	VIII	e, M	d. 2	0838		
in the		shock, or h	esrt fallure.	List only one cau	se on eac	ch line.	JO HOL SHES	r trie m	lode or dy	ing, sucr	n ss csrdia	c or respli	ratory srr	est,	Approximate Interval Between
		IMMEDIATE CAUSE (Final													
within 24 pletely fill cremation.		disease or condition resulting in death) Vannouna Trycycard 14													
		DUE TO (OR AS A CONSEQUENCE OF):													
executed and corr o burial.	z	Confective Hout Failure GUPRES													
	181	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										1			
trau	1 ()	cause. Enter UNDERLY	cause. Enter UNDERLYING CAUSE (Disease or Injury												
certificate ding physic tygiene pri	ERTIFI	that initisted events		DUE TO	(OR AS A C	CONSEQUENC	E OF):								
	E	resulting in deeth) LAS	T ,	1.											
the dear of the art of Menta	Ö	DART II. Osban alaniii	-1												
		PART II. Other significe	ent condition:	s contributing to	deeth but	t not result	ng in the u	nderlyl	ng ceuse (given in i	Part I. 2	4a. WAS AN A		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
signed by Health and	1 8										_ 1	YES 2	NO		COMPLETION DF CAUSE OF DEATH?
quires a signer Health												,			1 - YES 2 X NO
a Law requests been been of 1	AN:	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF	DEATH	YES 🗆	NO [UNC	ERTAIN					
	3	25. WAS CASE REFERRED TO		-		6. PLACE OF							_		
SICIAN: The law certificate has the State Dep	SICI	EXAMINER?		HOSPITAL:	FB/Output	Hent 3 🗆 DC	OTHE			ald	8 🗆 Other (S	D			
Sicia certif	РНҮ	27. MANNER OF DEATH		28e. DATE OF			TIME OF		JURY AT	rsiderice		RIBE HOW IN	I II IBV OCC	11050	
NG PHYS fer this path with		1- Natural 5	Pending	(Month, D			INJURY	W	YES 2	¬	and. DEGO	IIDE ITON III	JOH! OCC	UNED	
After death	B	a	Investigation	28a PLACE O	E IN HIDY	At home to				J NO	201 1 2 2 2 2			7 772	
TTENG TOR: A	8		Could not be datermined	28e. PLACE O building,	atc. (Specify	y)	m, street, tec	tory, om	ice	- 1	City or	ION (Street ei Town, State)	nd Number	or Rural Ad	oute Number,
OR ATTENDING ORECTOR: After hours after death item 28 is ma	<u></u>		(C=/iii) = \$10.00			-			_:-						
L OR / L DIRECT	립	29e. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowled	dge, death oc	curred at the	time, dat	te end place.	, end due i	to the cause	(s) end man	ner as atate	id.	
TO THE HOSPITAL OF THE FUNERAL CORP. TO THE FUNERAL CORP. TO THE WITHIN 72 IN IMPORTANT: If II	COMPLET														end menner ee stated.
S D M	U U	296. SIGNATURE AND TITLE	OF CERTIFIER	1 /					29c. LICE	NSE NUM	BER		29d DATE	SIGNED	(Month, Day, Year)
E E E &	8	(15m	1/1/	Tille	20				Do	7.5	UV	- 1	D 9	1/76	6
F F 8 3	임	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEAT	H (ITEM 27)	Type Drings		0	- / 0	17			1 4	115
		"FA HA? 1/	TAN-	110	21/1	1.1 1	20	_	ED		24	M			./
		31. DATE FILED (Month, Day,	THE	120 0500000	010	W 7	\$7.	. /	NEJ	ERI	CK.	111	_ d	170	/
		SEP 27	1995	32. REGISTRA	A SIGNAT	Rada	-								
-		טבו או	1333	Juna a	www.	Marke	84								

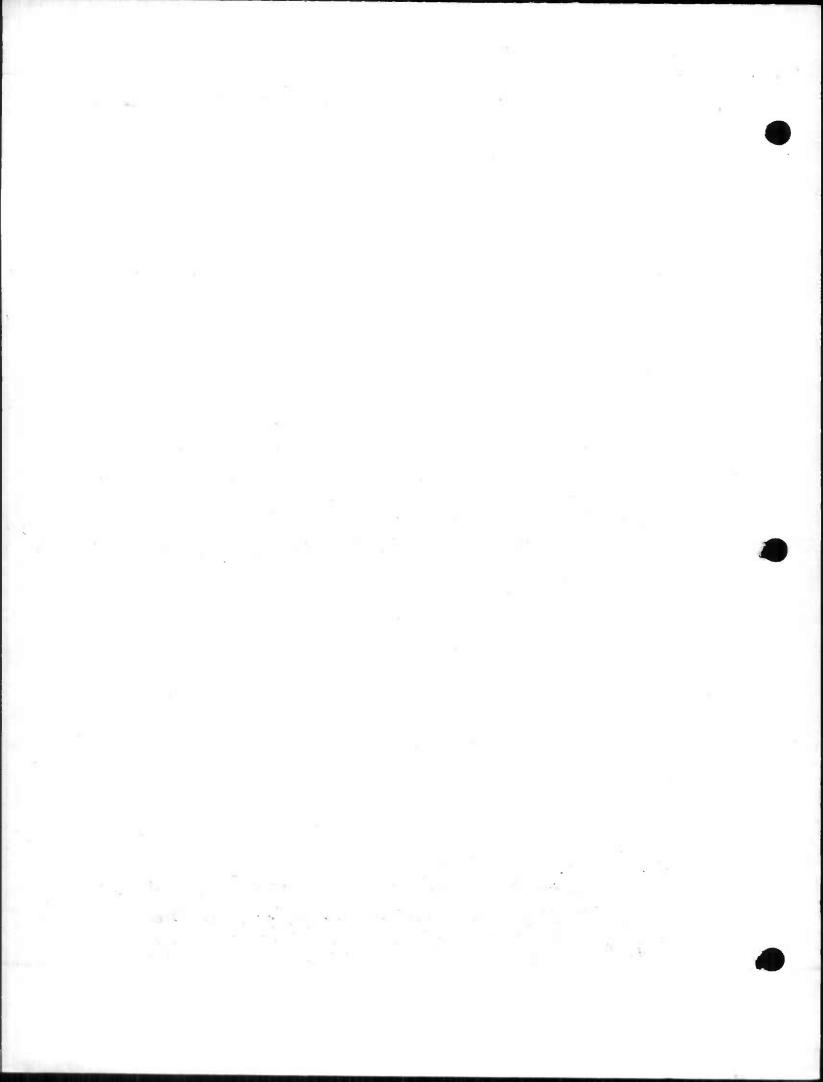


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if Hem 28 is marked, or Hem 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

	FOR STATE REGISTRAR	STATE OF MAR		DEPARTME				HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Nellie	Mae		Jones			2. DATE OF Sept.	2 9 ^{day} 1	995	3. TIME OF DEATH 12:26 P M
	212 21 1222	5. SEX 6. A	GE (In yrs. lest	birthday) IF UI MONT	NDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7, DATE OF (Month, De NOV •	sy, Ybar)	C	IRTHPLACE (State or Foreign ountry) aryland
	98. FACILITY NAME (If not institution, give stree The Memorial Ho			9b. (LOCATION OF DE Easton	ATH	9	Talbo	
JINECI	10s. STATE 10b. COUNTY Maryland Talb	ot		10c. CITY, TOY	on Locat				10d. INSIDE CITY LIMITS? t YES 2 XNO	
ENAL	100. STREET AND NUMBER 13809 Chu	rch Lane			101.	21625		. 1		OF WHAT COUNTRY?
DI LONG	11. MARITAL STATUS 1 t Never Married 2 Married 3 Widowed 4 M Divorced	2. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C	YES 2 XXV		If yes, spe	NDENT OF HISPAN city Cuban, Maxical 2 X NO Specify	n, Puerto Rice		1	RACE — American Indian, Black, White, atc. Specify: white
יירבובט	15. DECEDENT'S EDUCA (Specify only highest grade on Elementery/Secondary (0-12)	TION impleted) College (1-4 or 5 +)	(Gh	cedent's usua ve kind of work d Do NOT use retir homema	lone during mo: ed.)		16b. KII	ND OF BUSIN	ESS/INDUST	RY
200	17. FATHER'S NAME (First, Middle, Last) James R.	adcliffe	Jones			16. MOTHER'S NA Ly		He. Malden Sur ohnson	name)	
2	Ms. Greta Butts		196 5	322 Sk	ness (Street a ipjack	Drive,	Cambri	idge M	D 216	13
	20a METHOD OF DISPOSITION **T XBurtal 2 Cremation 3 Remove 4 Donation 5 Other (Specify)			nd DATE OF DIS	Memori	al Park				Maryland
	21. SIGNATURE OF PUMERAL SERVICE LICEN	1 Dans	2 h-		Thoma	o ADDRESS OF FA Funera Ocust St	1 Home		e MD :	21613
NO	23. PART I. Enter the diseases, or conshock, or heart fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Arter		LIGHT OF):		de of dying, such				Interval Between
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST d.	DUE TO (OR	AS A CONSEC	DUENCE OF):						
MEDICAL	PART II. Other significant conditions	contributing to dea	ith but not r	eauiting in th	e underlyln	ceuse given in		PERFORME	P7	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	BUTE TO CAUS		E OF DEATH (C		UNCERTAIL	NE			
r PHTSICIAN:	1 VYES 2 NO 27. MANNER OF DEATH 1 No Natural 5 Pending	1 □ Inpetient 2 □ ER 25a. DATE OF INJ (Month, Day, Y	URY		Nursing Hom 26c. INJ	RK?		Specify)	URY OCCURE	ED
2 Accident 3 Suicide 4 Homicide 5 Could not be determined 29a. CERTIFIER (Chock only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.								lure! Route Number,		
								ruse(s) end manner as stated.		
O BE	296. SIGNATURE AND TITLE OF CENTER					>86		1	P9 A	GNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO	an wil	P	6 Box	823	Easto	n, M	D s	1601	
	31. DATE FILED (Morith, Day, Year) OCT 0 3 1995 Julia dhurlage hardall									



pinous

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IDING PHYSICIAN: The law requires that the death certificate be executed withink fours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3	ation, or removal.	the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete!	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, crema	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

							95	3	1256	
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA	RTMEN	IT OF HEALTH AND E OF DEATH	MENTAL HYGIE				
DIRECTOR	1. DECEDENT'S NAME (First, Middle, Lest)	2. DATE OF DEATH MONTH	DAY 9	YEAR 3.	TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 220 - (6 - 490)	1 M 2 D F	(In yrs. last birthday	MONTHS		7. DATE OF BIRTH (Month, Day, Year) 4 10 2	_	Country)	IRTHPLACE (State or Foreign country) ARYLAND	
	99. FACILITY NAME (If not institution, give	street and number) MANC	R	M. SP. CI	illersuill	EATH	9c. COUNT	P OF DEAT	TH	
	10a. BTATE 10b. COUNT	NE ARUNDEL	10c. C		OR LOCATION THIAN			,	d. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER 5093 SANDS ROAD				101. ZIP CODE 20711		10g. CITIZE	USA	T COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1XXYE IF YES, GIVE WAR OF 1943 - 1	S 2 NO	13	B. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 X NO Speci	an, Puerto Rican, etc.)	be or No— 1	4. RACE — Black, W Specify: BLA	American Indian, filte, etc.	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 4th	College (1-4 or 5+)	16a. DECEDENT (Give kind of Ma. Do NOT PLUM	of work don use retired.	e during most of working		16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED			
BE CO	17. FATHER'S NAME (First, Middle, Lest) UNKNOWN 18. MOTHER'S NAME (First, Middle, Lest) ANNABELLE									
10	JAAMES W. JOHNSO	N	19b. MAILING ADDRESS (Street end Number or Burel Route Number, City or Town, Stele, Zip Code) 5093 SANDS ROAD LOTHIAN, MD. 20711							
	20a. METHOD OF DISPOSITION 1 XIXBuriel 2 Cremation 3 Ren 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	noval from State		VETE 22	ERAN CEME. 1	0/5/95 CR CLUTY MORTUARY,		LLE,		
TIFICATION	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	sed the death. Do	OF):	21 WEST ST. er the mode of dylng, aud	ANNAPOLIS,	MD . 2	1401	Approximate Interval Between Onset and Death ONE WEST		
BY PHYSICIAN: MEDICAL CER		dna contributing to deeth		g in the c	underlying couse given in		DRMED?	AM CC OF	ERE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE OBATH? YES 2 NO	
IYSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/O		1	28. PLACE OF DEATH (C) ER: ursing Home 8 Residence 28c. INJURY AT	8 Other (Specify)				
BY P	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO									

3 Suicide

4 Homicide

BE COMPLETED

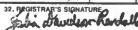
2

28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end meriner ee stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end m 29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)
OCT 05 1995



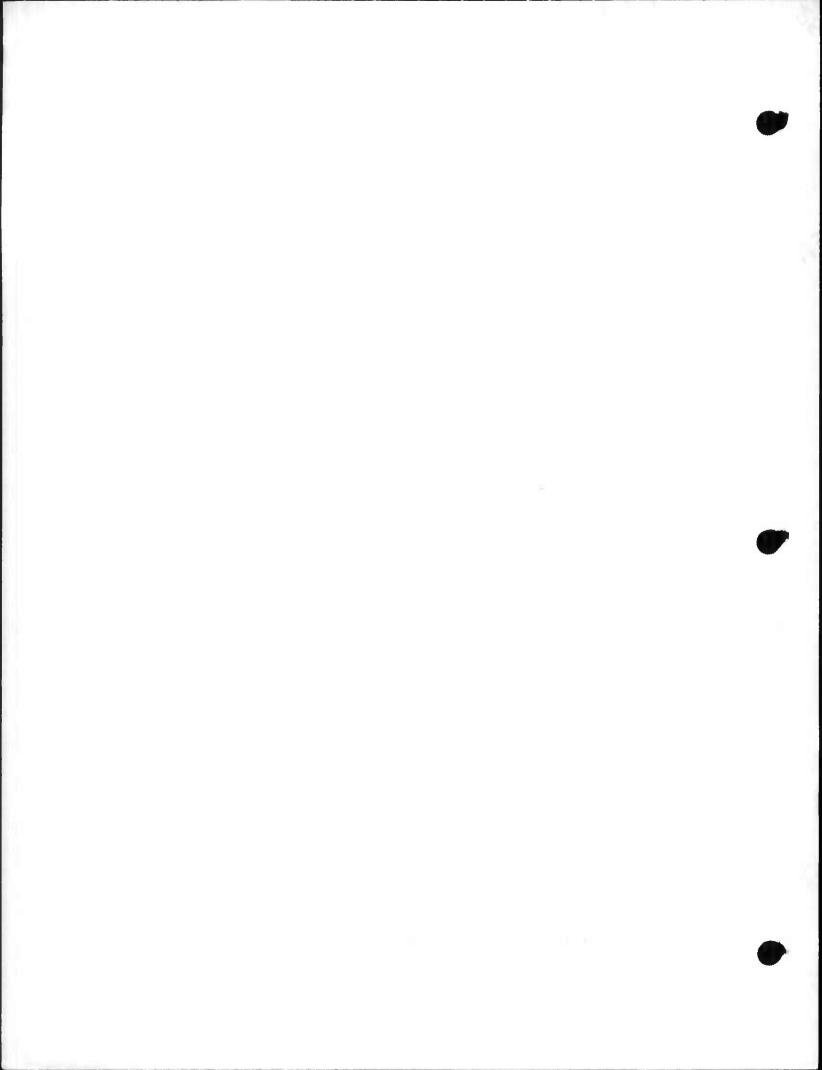
Will Bis Johnson Enter

68760	
BOX	
s, P.O	
RECORDS	
OF VITAL	
DIVISION	

31. DATE FILED (Month, Day, OC)

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH LOUIS JOHNSON EPT. 27 1995 0107 am 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 📈 M 2 🗌 F 218-26-1210 JUNE 12 MARYLAND permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL ANNAPOLIS 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1010 KENSINGTON WAY 21403 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) TES 2 NO BY Specify Specify: 3 Widowed 4 Divorced 1945 - 1946 BLACK COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) 12th CUSTODIAN NAVAL ACADEMY Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) ROBERT HAMPTON BE REBECCA WASHINGTON notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RACHEL JOHNSON 1010 KENSINGTON WAY ANNAPOLIS, MD. 21403 Page 6 may be pe 20e. METHOD OF DISPOSITION
1 A Burlel 2 Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must ANNAPOLIS MEM. GARDENS 9/30/95 4 Donation 5 Other (Specify) ANNAPOLIS, MD. 21 SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY death. REESE & SONS MORTUARY, P.A. Harri 2210 cuted within 24 hours after dead completely filled in by the fundal, cremation, or removal. WEST ST. ANNAPOLIS, MD. 21401 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between cremation, or IMMEDIATE CAUSE (Final Septic shock "Uvosepsis Onset and Death the disease or condition 24 hours resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): hysician and com; executed 2day traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): attending physician ntal Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other that initisted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST ò n signed by the attend f Health and Mental H Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL requires that any Stage veual ascase COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? Shows 1 TYES 2 T NO has been 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN The law Dept 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? this certificate State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: " Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 8 - Other (Specify) 4 Nurs 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED. with marked. Natural 2 Accident м 1 YES 2 NO After to death BY 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide .00 ETED. 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) DIRECTOR: A hours after d item 28 is 8 Could not be 4 Homicide determined COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and manner as stated. TO THE FUNERAL D be filed within 72 h IMPORTANT: If II (Check only one) HOSPITAL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month), Day, Year) BE 五五百 2 NESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) elouich. tracul 2140 MIO.

12. REGISTRAR'S SIGNATURE



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTII	RTMENT	OF H	EALTH DE AT	AND MEN	ITAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) CATHERINE	H. JONES					2.1	PATE OF DEATH IONTH PT . 22		95	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	T	E (in yrs. last birthday)	birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					19		0435 Ам		
	221-12-9502	1 M 2 X F	73 YRS.	MONTHS	DAYS	HOURS	MIN. SE	MONTH, Day, Year) PT. 23,	1921	8. BIRTHPLACE (State or Foreign Country) MARYLAND			
	9s. FACILITY NAME (If not institution, give		, ,	9b. CITY	, TOWN C	OR LOCATIO	N OF DEATH	11. 23,	9c. COU				
DIRECTOR	9625 MORRIS ROAD					ILLE				RCES			
ည္က ၂	10e. STATE 10b. COUNT	ГҮ	10c. CI	TY, TOWN C	OR LOCAT	ION					10d. INSIDE CITY		
	DELAWARE SUS	SEX		SELBY							1 YES 2 NO		
FUNERAL	RR 2 BOX 234B				101	1997			10g. CITI	ZEN OF V	A A		
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BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YE	DATES			ecify Cuban, 2 📉 NO		arto Rican, etc.)		Speci	k, White, atc.		
	15. DECEDENT'S EDI	1									WHITE		
ETE	(Specify only highest grad	e completed)	16a. DECEDENT'S (Give kind of life. Do NOT	work done i	during mo	ON st of working	,	16b. KIND OF BU	SINESS/IND	USTRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	SECRE	,				PETROL	TIM				
COMPL	17. FATHER'S NAME (First, Middle, Last)		DEGKE	IAKI		18. MOTH	ER'S NAME (F	rel RUL			100		
_	CHARLES C. HA	AMBLIN					CATE D		Junerney				
O BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS	(Street a			Number, City or Tow	n, State, Zip	Code)			
ĭ	BEATRICE ENNIS	5						O, DE 19					
	20a, METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Rem	noval from State	0b. PLACE AND DATE	E OF DISPOS	_				CATION —	City or To	wn, State		
	4 Donation 5 Other (Specify)		MILLSBOR	O CEM	ETE	RY	9	/23 MI	LLSBO	RO,	O, DE		
	21. BIGNATURE OF FUNERAL BERVICE LI	CENSEE	10	22.	NAME AN	D ADDRESS	S OF FACILITY	1					
	1 (Vigiles	W Hus	times	HA	STIN	GS FU	JNERAL	HOME, S	ELBYV	/ILL	E, DE		
	23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE DF):									Approximats interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (DR AS A CONSEDUENCE OF): c. DUE TO (OR AS A CONSEDUENCE OF):												
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5					,	, 3-		PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC								1 TYES 2	KNO		OF DEATH?		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗆 1	VO P	UNCE	RTAIN [1			1 YES 2 ND		
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE DF DEA		/-			- 1					
PHYSICIAN:	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	rtpatient 3 🗆 DOA	OTHER 4 Nurs	t: Ing Hom	5 Resi	idenca 6 🗆 (Other (Specify)					
Ē	27. MANNER OF DEATH	28s. DATE DF INJURY (Month, Day, Year)			28c. INJI	URY AT		DESCRIBE HOW II	NJURY OCC	URED			
	Natural 5 Pending Accident Investigation	(MONT, Day, Tear)	""	M		ES 2	ND						
- 61	3 Suicide 6 Could not be	28e. PLACE OF INJUI building, atc. (Sp	RY — At home, farm,	street, tact	ory, office	,	261.	LOCATION (Street a	and Number	or Rural A	loute Number,		
261. LOCATION (Street and Number or Rural Route detarmined at the time, data and place, and due to the cause(s) and manner as stated. 262. CERTIFFIER (Check only one) 263. CERTIFFIER (Check only one) 264. CERTIFFIER (Check only one) 265. COCATION (Street and Number or Rural Route City or Town, State)								Only or rown, state)					
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	30. NAME AND ADDRESS OF PERSON WE Stever C				-	Kay	A	UPAUP.	Sal	1460	144, MD		
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SHE	NATUREO			1.1.4	/ 1)	2 -11	. / +0	21501		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

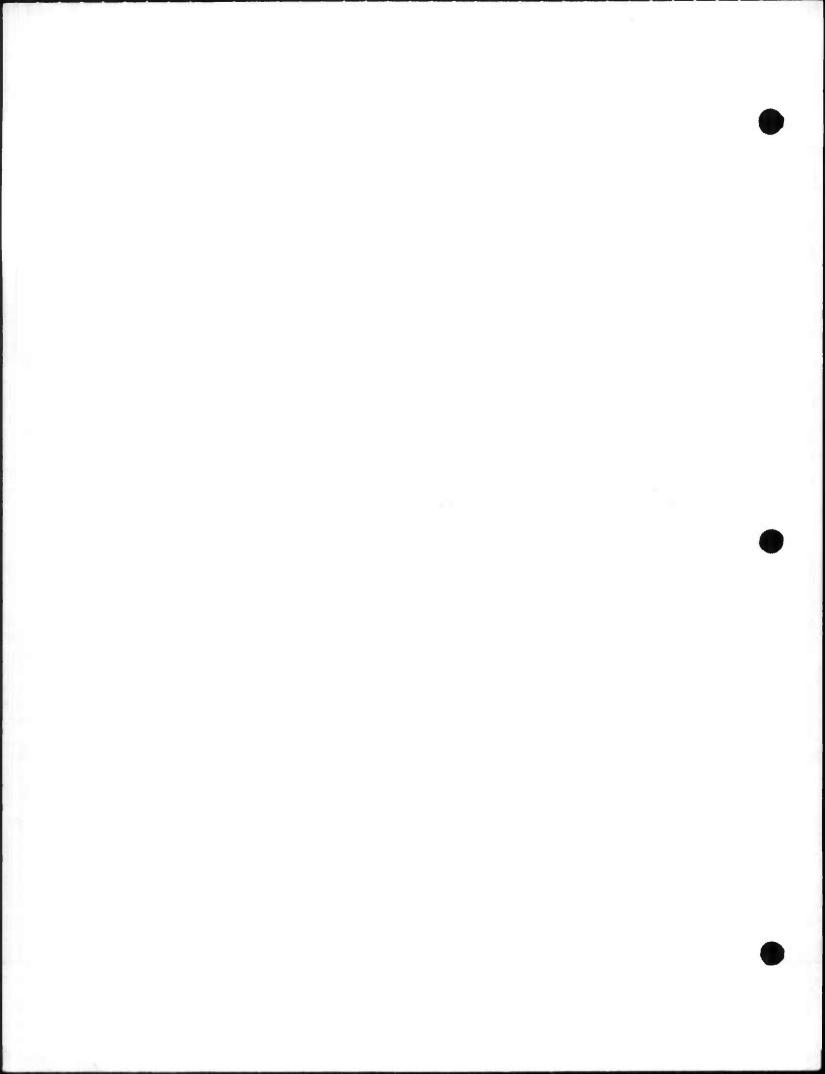
DIVISION OF VITAL RECORDS, P.O. BOX 68760

LOUIS JOHNSON

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATKINS (OU RESULTED WAY Print), SALIS, MD ZIBII 31. DATE FILED (MONTH, Dey, Year) 32. MEGISTRAP'S SIGNATURE		REGISTRAR		CERTIFI	CATE OF	DEATH	R	EG. NO.			
SALISBURY NURSING REPARA CENTER SALISBURY NURSING REPARA CENTER		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. TIME OF OE	ATH
SALISBURY NURSING REPARA CENTER SALISBURY NURSING REPARA CENTER	1	LOUIS	PARKER	JOHN	SON		SEPTEN	BER 16	1995	8:45	Дм
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James A. Johnson P.O. Box 112, Fruitland, MD 21826 200. PLACE AND DATE OF DEPOSITION DATE DR. LICATION - City of Town, State Control Con	8		Johnson								
TO SHAPE AND DATE OF BEPOSITION Name of Control State 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 201. Salisbury, MD 21801 21. MANE AND ADDRESS OF PERSON (Prime Prime State) 200. BEPOSITION (Prime of Disposition) 200. BEPOSITION (Prime of Disposition) 201. Salisbury, MD 21801 21. MANE AND ADDRESS OF PERSON (Prime Prime State) 202. MANER AND ADDRESS OF PERSON (Prime Prime State) 203. BEPOSITION (Prime Prime State) 204. DEPT (Prime Prime State) 205. BESCHART (PRIME PRIME CONTINUE) 206. DEPT (Prime Prime State) 206. DEPT (Prime Prime State) 207. DEPT (Prime Prime State) 208. BESCHART (PRIME PRIME CONTINUE) 208. DEPT (Prime State) 209. DEPT (Prime Prime											
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The Books, or heart failure. List only one cause or sealth. Do not enter the mode of dying, such as cardiac or respiratory arrest, leaves, or heart failure. List only one cause on such line. 10		1 X Burial 2 ☐ Cremation 3 ☐ Remov	rel from State CO	metery, crematory or oth	er place)		1		-		
Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 af Pert Letter the diseases, or complications that gesself the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, interval Between the case or condition af Pert Letter the diseases. Or condition that gesself the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, interval Between the case or condition and the case of condition and the case of condition and the case of condition and the case of condition and the case of conditions. Sequentially list conditions. In any, leading to immediate case. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CACHARY A CONSEQUENCE OF CONTRIBUTE TO CAUSE OF DEATH YES IN ON UNCERTAIN IN ON OF CAUSE OF DEATH OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUTE OF CACHARY A CONTRIBUT			W	icomico M	emorial			Salisb	ury,	MD	
Solid Show Hill Rd., Salisbury, MD 2180		21. SIGNASURE OF OBJERAL SERVICE LICE	hage 1					omo			
Approximate interval acardisc or reapiratory arrest, approximate inches, or peace or act falline. List only one osus on acts line. IIMMEDIATE CAUSE (Final desease). The provided of the cause of acts in the peace of act		Sport. H	Ol Voux	7					irv.	MD 2180	1
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1										1 YES 2	NO
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) 31. DATE FILED (Month, Dey, Year) 32. PEGISTRAR'S SIGNATURE)	A I		BOTE TO CAUSE (UNCERIAI	4 L				
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3 Suicide 4 Homicide 6 Could not be detarmined 29a. CERTIFFIRE (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. PEGISTRAR'S SIGNATURE)		1 Netural 5 Pending		INJU	RY WO	RK?	20d. DESCHIB	E HOW INJURY OF	CURED		
4 Homicide detarmined detarmined detarmined Duilding, stc. (Specify) City or Town, State) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. PEGISTRAR'S SIGNATURE) 31. DATE FILED (Month, Day, Year) 32. PEGISTRAR'S SIGNATURE) 4.60		a Destate	28a PLACE OF INJUR	Y — At home from etc.			201 1 2 2 1 7 2				
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATKINS (OU RESULTED WAY, Print) 31. DATE FILED (Month, Day, Year) 32. AFGISTRAP'S SIGNATURE)		Could not be	building, atc. (Spe	cify)	eat, rectory, orne	7	City or Toy	vn, State)	or Hural E	toute Number,	
296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. DATE SIGNED (Month, Dey, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATKINS (OU RESULT) WAY Print, SALS, MD 21831 31. DATE FILED (Month, Dey, Year) 32. MEGISTRAR'S SIGNATURE)	۳ ا	29e. CERTIFIER 1 CERTIFYING BUYERS	AN. To she have at all and a							-	
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATKINS (OU RESULTED WAY, Print) 31. DATE FILED (Month, Day, Year) 32. AFGISTRAP'S SIGNATURE)	₹										
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATKINS (OU BESTELL WAY DIVINE, SALES, MD 21851) 31. DATE FILED (MONTH, Dey, Vear) 32. MEGISTRAN'S SIGNATURED	w II	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	IBER	29d. DA	TE SIGNED	(Month, Day, Year)
MATKINS (OU RESULTED WAY PINE, SALIS, MD ZIBS) 31. DATE FILED (MONTH, Day, Year) 32, MEGISTRAP'S SIGNATURED		· m	m m	0		039	313		9/10	5/98	
31. DATE FILED (Month, Dey, Year) 32. AEGISTRAR'S SIGNATURD				EATH (ITEM 27) (Type, P	el De	my K	27rm	L. SA	us,	MOZI	168
	5	31. DATE FILED (Month, Day, Year) SEP 2 0 1995	32. MEGISTHAR'S SIGN		-		•				



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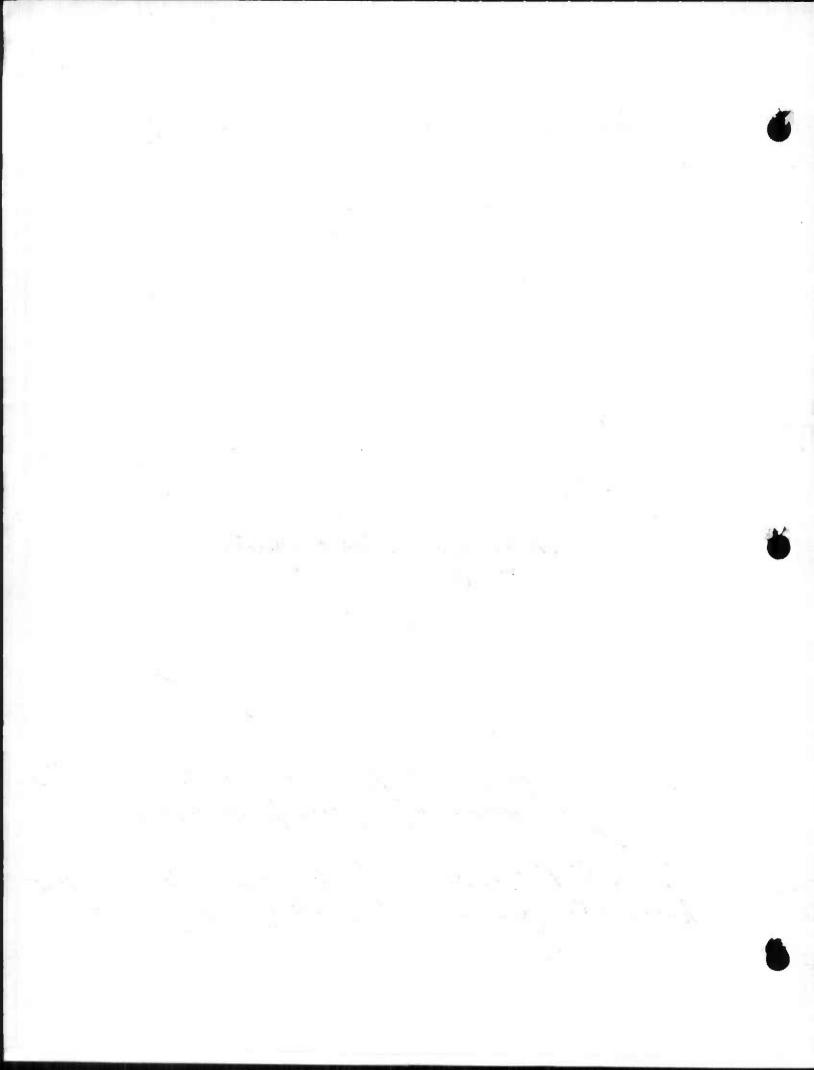
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending	TO THE PLINETAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bortal, cremation, or removal.	IMPORTANT: It lear 28 is marked, or item 23 shows any injury, or other traumalic event, the medical examiner must be notified at once
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Land) 2. DATE OF DEATH 1. TIME OF DEATH Cofober 64 heo 4. SOCIAL SECURITY NUMBER 6. AGE (N) yes, last birthday; 7. DATE OF BIRTH (Morth, Dey, Year S. SEX IF UNDER 24 HRS. PLACE (State or Foreign July 9 1934 DAYS 1 X W 2 | F West Virginia 223-42-0206 BE FACILITY MAME (F nor institution, give street and number)
Prince George's Hospital Bb. CITY, TOWN OR LOCATION OF DEATH
Prince George's BE COUNTY OF DEATH Prince Georgia DIRECTOR RESIDENCE OF DECEDENT 10s. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia Fairfax Alexandria 1 TYES 2 X NO 10s. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101, 71P CODE 6211 Richmond Hwy 22303 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCESY 1 YES 2 2NO 13. WAS DECEMBENT OF HISPANIC CHIGIN? (Specify Yes or No-14. RACE — American Indian Black, White, etc. 3 740 1 Never Married 2 X Married If yes, specify Cuban, Mesican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES WHITE 1 TYES 2 DONO Specify B 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION worky only highest grade complex 16a. DECEDENT'S UBUAL OCCUPATION (Size kind of work done during most of working the Do MOT use ratins).) 166. KIND OF BUSINESS/INDUSTRY (Spe nentary/Secondary (0-12) College (1-4 or 5 +) 5 Self Construction 17. FATHER'S NAME (First, Mickille, Last) TB. MOTHER'S NAME (First, Mickelly, Maiden Surname) Wesley I Kile Martha Bradley 19s. INFORMANT'S NAME (Type/Frint) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Timer, State, Zip Code) 2 Michael Waller 6211 Richmond Hwy Alex. VA METHOD OF DISPOSITION
Burial 2 Cremation 3 Pa
Donation 5 Other (Specify) 29b. PLACE AND DATE OF DISPOSITION / Nortice of 107,95 20c. LOCATION - City or Town, State Rawley Spring Cemetery Rockingham Co, VA III. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA 23. PART | Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death IMMEDIATE CAUSE (Final disease or condition___ fly in pines with complications resulting in death) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO JOR AS A CONSEQUENCE OF: that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE T YES 2 PHO OF DEATHY 1 YES 2 HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH /Check only o 1 YES 2 NO 27. MANNER OF DEATH 38b. TIME OF 28c, INJURY AT WORK? 444 1 Negural
2 Accident 1 YES BY 3 Suicide 8 [] Could not be COMPLETED 4 [] Homicide 1 CERSOFVING PHYSICIAN: To the Se 2 MEDICAL EXAMINER: On the BE 2

32. REGISTRAR'S SIGNATURE

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31. DATE FILED (Month, Day, Year)

LETED CAUSE OF DEATH (LIEM 27) (Type

Julia Shvalyn Randall

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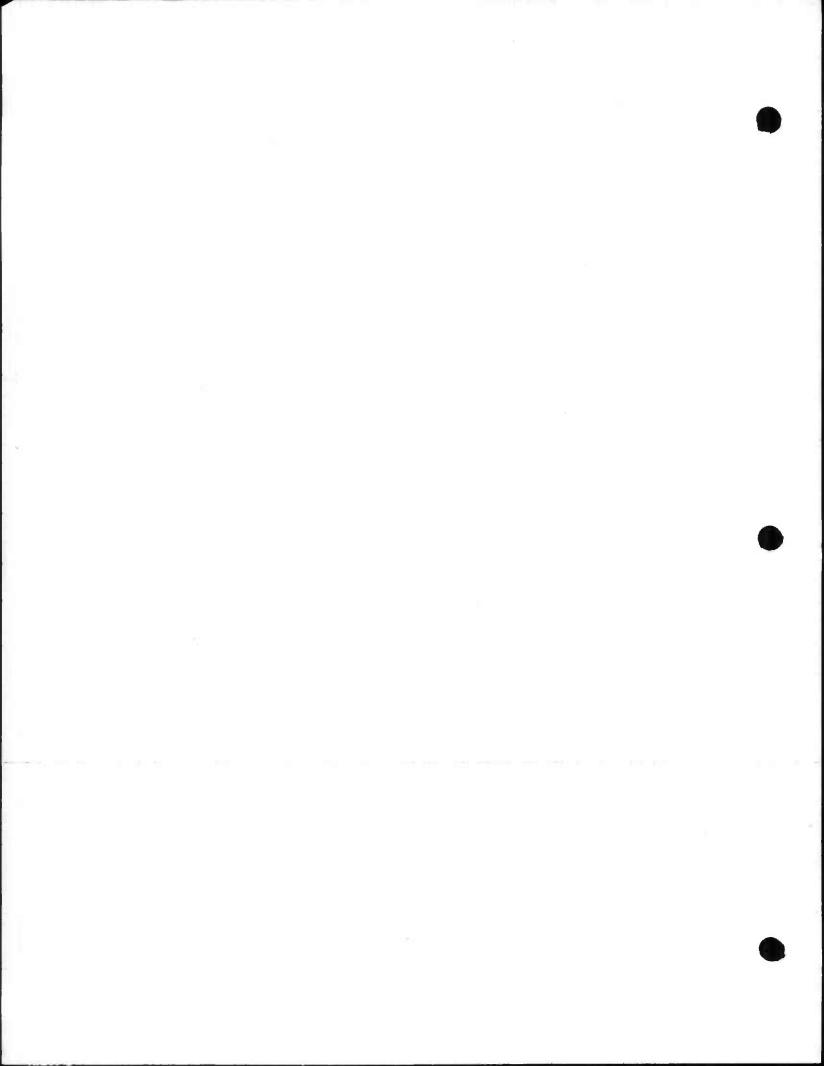
STATE OF THE COUNTY, T.O. BOX 80/50	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be encoured within 74 hours after de-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the last	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burst, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical ex-
	OR AT	DIREC	hours a	Item 2
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Annie Virginia Lofthouse Sept 30 9:10pm 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 24 HRS 8. SIRTHPLACE (State or Foreign 83 1 M 2 X F 213-18-0005 Mar 22 191 Virginia Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Calvert Manor Healthcare Center DIRECTOR Rising Sun Cecil RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Cecil Rising Sun 1 - YES 2 - NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 184 Ridge Rd. USA 21911 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If was, specify Cuban, Maxican, Puarto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puarto Ri

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: white 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high H College (1-4 or 8+) COMPL 12 Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Burton M. Boyd, Charlotte A. VanDyke 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 C. Dale Lofthouse 184 Ridge Rd Rising Sun MD 21911 20a, METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cametery, crematory or other place)
West Nottingham Cemetery 1:0-3-4 - Donation 5 - Other (Specify) 995 Colora MD 21. SIGNATURE OF PUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY -24 R. T. Foard Funeral Home, PA 111 S Queen St Rising Sun MD 21911 23. PART I Enter the diseases, or complications that caused/the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heert fellure. List only one gause on such line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF UltrALVULA CERTIFICATION Sequentisly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, lesding to immediate csuse. Enter UNDERLYING CAUSE (Disesse or injury LOUNY DUE TO (OR AS A/CONSEQUENCE OF that initieted events resulting in death) LAST Wa 110 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 AO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{\text{NO}}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) 1 YES 2 HO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296, SIGNATURE AND LE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2



ained by the hospital or attending physician. hould be detached for use as the burfat-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

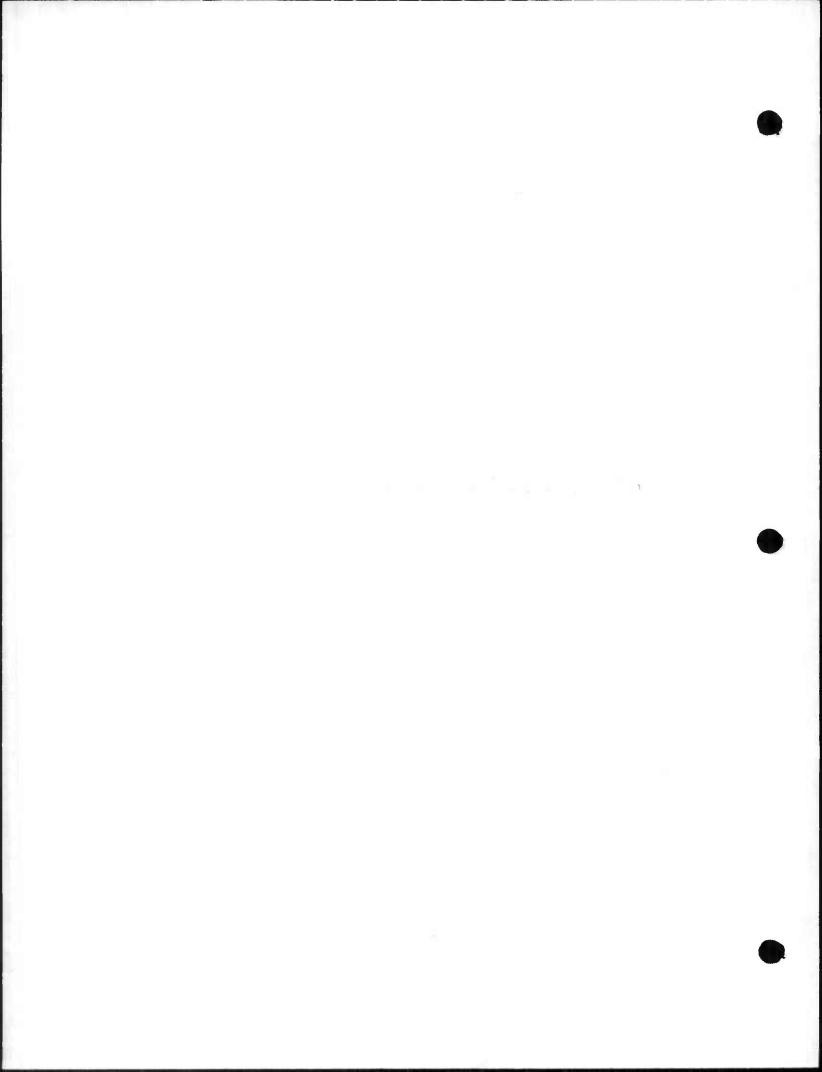
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DIVISION OF VITAL RECORDS, P.O. BOX 88780	IE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta	IE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF H	HEALTH AND I	MENTAL HYGI		
	1. OECEDENT'S NAME (First, Middle, Lest)	Iris Olive	Luc			2. DATE OF DEATH Septemb	DAY	3. TIME OF DEATH
1	4. SOCIAL SECURITY NUMBER		Lyo	IF UNDER 1 YEAR	IF UNDER 24 HRS.			17995 11:50
	222-03-3344	1 M 2 🔀 F	90 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	L. BIRTHPLACE (State or Foreign Country)
	9e. FACILITY NAME (If not institution, give str	reet and number)	1,000	9b. CITY, TOWN	OR LOCATION OF DE	February	-	Maryland Y OF DEATH
DIRECTOR	Wicomico Nur	sing Home		S	alisbur	У	Wi	comico
RE	10a. STATE 10b. COUNTY			TOWN OR LOCA				10d. INSIDE CITY
		v Castle		Wilming				1 TYES 2 X NO
FUNERAL	100. STREET AND NUMBER 405 Rowland Park	e Blud.		10	19803		10g. CITIZE	EN OF WHAT COUNTRY? USA
18	11. MARITAL STATUS	12. WAS DECEDENT EVER (F	U.S. ARMED	13. WAS DEC		IIC ORIGIN? (Specify	Ves or No 1	
	1 Never Married 2 Married	FORCES? 1 YES		If yes, sp		n, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify:
) BY	3 🔀 Widowed 4 🗌 Divorced				- A-			White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S I (Give kind of w life. Do NOT use	ork done during me	ON ost of working	16b, KIND OF	BUSINESS/INDU	STRY
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Clerk	retired.)		State	of De	laware
O.	17. FATHER'S NAME (First, Middle, Lest)				18, MOTHER'S NA	ME (First, Middle, Maid		
114	Ernest Mario	n Mills			Louis			ley
TO B8	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or		
F	Sarah S. Hopkins	S	103	Loch Ra	ven Rd.,	Salisbur	y, MD	2 180 1
	20e. METHOD OF DISPOSITION N Burial 2 □ Cremation 3 □ Remo		PLACE AND DATE O			1		ty or Town, State
	4 Donation 5 Other (Specify)	100	etery, cremetory or off dd Fellov				Seaford	, De
	1 Comme service in	7601			loway Fur	neral Hom	e	
	11.1	se your	1	501	Snow Hi	L1 Rd., S	alisbur	y,MD 21801
	23. PART I. Enter the diseases, or co shock, or heart fallure. L	omplications that cause list only one cause on e	the deeth. Do not	ot enter the mo	de of dying, auc	h aa cardiac or re	apiratory arres	Approximate interval Betw
	IMMEDIATE CAUSE (Final disease or condition	07.	1 0	7	.71	40		
	resulting in death)	urcer	issel	uotu	Hear	1 Hes	erro	5 yr
_	_	General General	CONSEQUENCE OF	De	iano.			611
ě	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	- cc	roses		390
3	cause. Enter UNDERLYING CAUSE (Disease or injury							
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				
AL CERTIFICATION								
AL	PART II. Other aignificent conditions	contributing to death b		the undarlying	g ceuse given in	Part i. 24a. WAS	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDIN
일	Organie	Brain.	sime	rome			2 OF NO	AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
: MEDIC	Hyperten	sion Ex	sentia	e		_	•	1 YES 2 NO
	DID TOBACCO USE CONTR			S NO	UNCERTAIN	1 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATI	OTHER:				
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIME		e 5 Residence		W B1 H IDV AAA1	050
	1 Netural 5 Pending	(Month, Day, Year)	INJU	IRY WO	PRK?	28d. DESCRIBE HO	W INJUNY OCCU	RED
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, term, st			281. LOCATION (Street	et end Number or	Rural Route Number,
ETE	4 Homicide determined	building, etc. (Spec	ny)			City or Town, Ste	ete)	
PLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edge, death occurred	d at the time, date	end place, end due	to the cause(a) and r	nenner as stated	
COMPL								ceuse(e) end manner ee stated
w	296. SIGN TURE AND TITLE OF CERTIFIER	02 00			29c. LICENSE NUM	BER	29d. DATE S	SIGNED (Month, Day, Year)
O BE CO	pregen h	, Bella	w Wh	2D	D29.	505	19-	25-95
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)		011		21817 RISFIELD MO
	GKEGORIO F	1, BELL	080, M.	D. 442	21 BEE	LH WOOD	PL. el	RISFIELD MI
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	7				
1 - 3	SEP 26 1995	المالين المالية	rootet					

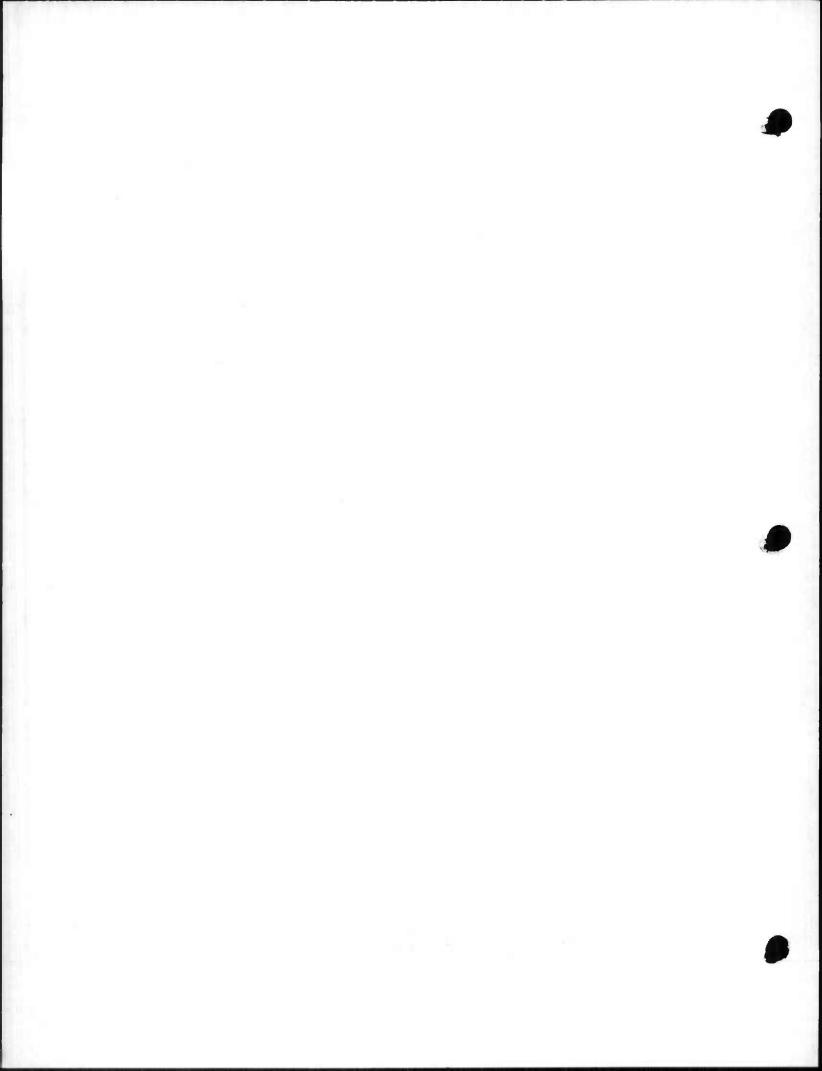


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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IMPURIANT: IT ITEM 28 IS MARKED, OF ITEM 23 SHOWS ANY INJURY, OF DIRECT DAMPED COVERT, THE MEDICAL EXAMINER MUST BE NOTICE.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYG		
	1. DECEDENT'S NAME (First, Middle, Last)		OLITTI I	OAIL OI	DEATH	2. DATE OF DEAT		3. TIME OF DEATH
	John Michael L	ePore				Sept 1	8 1995	8:30 a M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTS	н в	BIRTHPLACE (State or Foreign
	221-18-5607	1 🖟 M 2 🗆 F 6	4 YRS.	NONTHS DAYS	HOURS MIN.	July 1,	1931	Maryland
_	9a. FACILITY NAME (If not institution, give stre			9b. CITY, TOWN C	R LOCATION OF D			Y OF DEATH
DIRECTOR	18402 LePore Road			Maryd	el		Caro	oline
RE	10s. STATE 10s. COUNTY		10c. CITY,	TOWN OR LOCAT	ION		_	10d. INSIDE CITY LIMITS?
	Maryland Carol	ine		Maryd				1 YES ZENO
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
NE	18402 LePore Road				21649			J.S.A.
	1 Never Married 2 Married	12. WAS DECEDENT EVER IN U FORCES? 1 YES	2 NO	If yes, sp	ecity Cuban, Mexic	NIC ORIGIN? (Special an, Puerto Rican, etc.		I. RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 TYES	2 NO Speci	fy:		Specify: White
0	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S U	SUAL OCCUPATIO	ON .	16b, KIND O	F BUSINESS/INDUS	
ᄪ	(Specify only highest grade co	College (1-4 or 5+)	ife. Do NOT use	retired.) Opera	tor			
MP	10		auto	body re	pairman	1	ocal aut	to body shop
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Mi		
BE	Joseph William Le	Pore, Sr.			Pearl (Cox LePor	e	
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City o		ode)
	Phyllis B. LePore					larydel,		
	20e. METHOD OF DISPOSITION 1 Burtlel 2 □ Cremation 3 □ Remove	al from State 20b.P	PLACEAND DATE OF BOY, Cremetory of oth Greens bo	DISPOSITION (Na er place)	me of	1	c. LOCATION — CH	
	4 Donation 5 Other (Specify)		Greensbo		Cery	9/21	Greenst	oro, Maryland
	A /	60	/			enbein Fu	neral Ho)me
	Ment	Rugh		P.O.	Box 160	Greensh	oro Mar	vland 21630
	23. PART I. Enter the diseases, or conshock, or heart fallura. Lie	mplications that caused t at only one cause on eac	ths death. Do no th line.	t enter the mo-	de of dying, suc	ch ss cardine or i	espiratory srres	t, Approximats
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death
	reaulting in death)		mone					
		DUE TO (OR AS A C	CONSEQUENCE OF)					/1
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A C	ONSEQUENCE OF	un				tycons
X	if any, leading to immediate cause. Enter UNDERLYING							
Ĭ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF)					
E	resulting in death) LAST							
	PART II. Other algnificent conditions	contributing to death but	not regulting in	the underlying	Lagues alum In	Don't at un		1
CAL	The state of the s	contributing to deeth but	not reauting in	the underlying	reuse given in	PE	S AN AUTOPSY RFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
						1 🗆 YE	S 2 NO	OF DEATH?
Σ								1 TES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26 Pt	ACE OF DEATH (C)	and and and		
Sic		HOSPITAL:		OTHER:				
Ä	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c, INJI	JRY AT	8 Other (Specify, 28d, DESCRIBE H	OW INJURY OCCUP	RED
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WO	RK? ES 2 NO			
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — building, etc. (Specify	At home, term, etr	eet, factory, office		28f. LOCATION (SI	reet and Number or	Rural Route Number,
	4 Homicide determined	bunding, etc. (Specify	,			City or Town, S	State)	
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowled	ige, death occurred	of the time, date	end piece, and due	to the couse(s) end	menner as stated.	
∑								ause(s) and manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	1	445		29c. LICENSE NU			IGNED (Month, Day, Year)
BE	(HT >)	Late	MD	Ì	D47	492	1 9	119195
임	30. NAME AND ACTORESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, F	rint)		112		
	lettray T.	Dentan,	MD P	OBOX	122 (Tolds 600	ro MI	21636
	31. DATE FILED (HOND DOY, MOT) '95	32. REGISTRAR'S SIGNAT	Ison-Rande					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-solurs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

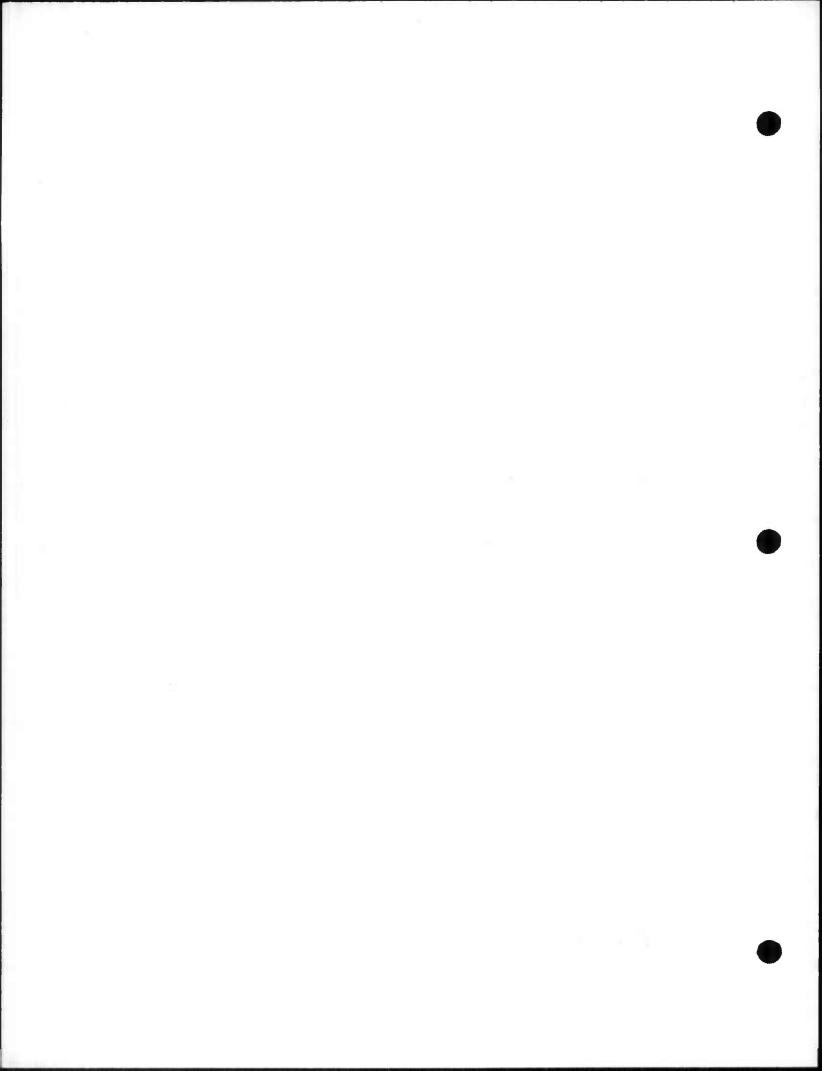
OCT 0 3 1995 John of Museum Control

Ame	ended #1, 10/10/1	995. L.L.	S,Some	rset C	0.			
	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF	HEALTH AND			
	1. DECEDENT'S NAME (First, Middle, Last)	Lawrence	ancoc			2. DATE OF DEATH MONTH		YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5.	SEX 8. AGE (II	yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	44	1906	8. BIRTHPLACE (State or Foreign Country) New York
	Se. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF			UNTY OF DEATH
DIRECTOR	MANOKIN MANOR NURS	ENG HOME		PRINC	ESS ANNI	E		SOMERSET
REC	10a. STATE 10b., COUNTY		10c. CIT	Y, TOWN OR LOCA	ATION			10d. INSIDE CITY
	MARYLAND SOMEF	₹SET	PF	RINCESS				1 X YES 2 NO
FUNERAL	11974 EDGEHILL TERF	RACE LANE		1	21853		10g. CI	TIZEN OF WHAT COUNTRY?
NO.	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	CENDENT OF HISE	PANIC ORIGIN? (Specify	Yes or No-	U.S. 14. RACE — American Indian.
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO TES	If yes, s	pecify Cuben, Mex S 2 NO Spe	icen, Puerto Rican, etc.)		Black, White, etc. Specify: WHITE
TED	15. DECEDENT'S EDUCATION (Specify only highest grade company)	DN pleted)	16a. DECEDENT'S (Give kind of life. Do NOT us	work done during m	ION ost of working	16b. KIND OF	BUSINESS/IN	
COMPLET	Elementery/Secondary (0-12) Co	ollege (1-4 or 5 +)		EWIFE		OWN F	IOME	
CON	17. FATHER'S NAME (First, Middle, Last)		110001	-1171 -	18. MOTHER'S	NAME (First, Middle, Meid		
BE	ALBERT SEWELL BENSO	ON				Y HUCKANS		
5	194. INFORMANT'S NAME (Type/Print) MARY FRANCES BOZMAN	AJ.				al Route Number, City or		
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal	20b.I	PLACEANDDATE	OF DISPOSITION (A	ame of			NE, MD. 21853 City or Town, State
	4 Donetion 5 Other (Specify)	B	EECHWOO	CEMETE	RY			SS ANNE, MD.
	21. SIGNATURE OF FUHERAL SERVICE LICENSE	EE.			AN FUNE	FACILITY RAL HOME		
-	Mnest Klex	man/M00:	294	PRTN	ICESS ANI	NE MD 21	.853	
- 1	23. PART I. Enter the diseases, or comp shock, or heart failure. List IMMEDIATE CAUSE (Final	only one cause on as	tha death. Do r ch lina.	ot anter tha me	oda of dying, au	uch aa cardiac or re	epiratory ar	Interval Batween
	at the state of th	Arteria	2000	ot.	H	et D.		Onset and Death
		Arterio DUE TO (OR AS A C) Arterio	CONSEQUENCE OF	7:	4	w (MS	Consider	40 gre
NO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF	lero.	n			60 yrs
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury							0
THE	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	7):				
CE	d							
CAL	PART II. Other aignificant conditions co	ntributing to death but	t not reaulting I	n the underlyin	g cause given I		AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDICAL	- Grant	02.112	7	ark	M.C.	1 🗆 YES	2 NO	COMPLETION OF CAUSE OF DEATH?
Z ≥								1 TES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:		OTHER:	LACE OF DEATH (C	Check only one)		
HYS	1 VES 2 NO 1 C	Inpetient 2 ER/Outpet	lent 3 DOA	4 Nursing Hon	ne 5 🗆 Residence	8 Other (Specify)		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		PRK?	28d. DESCRIBE HOV	Y INJURY OC	CURED
- 1	3 Suicide 6 Could not be dates without	28e. PLACE OF INJURY — building, etc. (Specify	At home, ferm, s	treet, factory, offic		28f. LOCATION (Stree City or Town, Ste	et and Number fe)	r or Rural Route Number,
P.E.	290. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	. To the beat of my knowler	ige, death occurre	d at the time, date	and place, end du	e to the cause(e) end n	nenner es ste	ted.
COMPLETED	one) 2 MEDICAL EXAMINER: On	the basis of examination of	end/or investigation	n, in my opinion, c	leath occured at th	ne time, date and place,	end due to th	he ceuse(e) end menner as stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	2.4.			29c. LICENSE NO	UMBER	29d. DAT	E SIGNED (Month, Day, Year)
24	30. NAME AND ADDRESS OF PEASON WHO COI	MPLETED CAUSE OF DEAY	H (OTEM 27) / X	Dolad)	7576	70	1	10/3/95
	The. L. M. Eva	ugelis	CO2 (1) (1) PO.	10:3	The	e Roll	tt. 1	Cd #K

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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND I	MENTAL HYGIE			
		1. DECEOENT'S NAME (First, Middle, Last					2. DATE OF DEATH		YEAR 3. 1	TIME OF DEATH
,		Manuel F		DZano In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Sept. 2	26, 19	95	10:09 PM
pin		218-48-0739 9a. FACILITY NAME (If not institution, give	1 🕱 M 2 🗆 F 5	3 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Jan 8,1	942 5	outh	
2, 3 should	TOR	604 Sunnybro		#1011		nersburg			y of DEATH ntgo!	
iges 1, 3	DIRECTOR	10e. STATE 10b. COUN		10c. CIT	Y, TOWN OR LOCAT	TION			10d	. INSIDE CITY
permit. Pages		Maryland Mon 10a. STREET AND NUMBER	tgomery	G	aithers	burg		10g, CITIZE	1 E	LIMITS? YES 2 NO
15	FUNERAL	604 Sunnybroo	k Terrace -	Apt 1	011	20877			1 umb	
ing physician. the burial-transit	BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2X NO	If yes, sp	ecify Cuban, Mexica 2 NO Specify		Yes or No 14	Black, Wh	American Indian, lita, atc.
r attending use as the	ED	15. DECEDENT'S ED (Specify only highest grad	UCATION		USUAL OCCUPATION	ON	Americ	USINESS/INDUS		nite
6 5	LET	Elementary/Secondary (0-12)	College (1-4 or 8+)	Ille. Do NOT us			77	0-		
the hospital o detached for once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last)	4	Sales	Manage		ME (First, Middle, Maid	Garme	ents	
5 2 %	ш		zano				eatriz		obar	
5 should	TO B	19a. INFORMANT'S NAME (Type/Print)			AODRESS (Street a		Route Number, City or T			20877
	-	William B. Ro					race, Ga	ithers	sburg	- M1
age 6 may be director, page er must be		20a. METHOD OF DISPOSITION 1	movel from State 20b.	PLACE AND DATE OF STREET, Crematory or of	her place!		DATE 20c.	LOCATION - CH	y or Town, !	20814
B 5		21, SIGNATURE OF FUNERAL VERVICE L	ICENSEE	nregome:	22. NAME AP	ND ADDRESS OF FA	CILITY B	ethese	ld, Mo	aryland
		Donert L	. William	w	01 in	L. Mole	sworth,	Р.А.,	Fune	eral Homo
of withings hours after ompletely filled in by th i. cremation, or remove event, the medical		23. PART I. Erfal the diseases, or shock, or heart fallure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. COMPLICA DUE TO (OR AS A DEFICE	nch line.	ot enter the mo	de of dylng, suci	n aa cardiac or res	spiratory arrea	it,	Approximate Interval Between Onaet and Death YEARS .
emilicate be executed ing physician and con giene prior to burial, other traumatic e	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	BROM	E			
a de pa	ERTI	resulting in death) LAST	d.							
requires that the deat een signed by the ath of Health and Mental shows any Injury,	MEDICAL C	PART ii. Other significant condition	na contributing to death be	ut not resulting i	n the underlying	g cause given in		AN AUTOPSY ORMED?	COM OF E	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 - NO
has been Dept. of 23 she		DID TOBACCO USE CON				UNCERTAIN	1 🗆			
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:	~				
certificate in the State d, or liter	H	27. MANNER OF DEATH	1 Inpatient 2 ER/Output	28b. TIM	E OF 26c. INJ	e 5 Rasidence	8 Other (Specify) 26d. DESCRIBE HOW	V INJURY OCCUP	RED	
THE PERSON	BY P	1 Netural 8 Pending 2 Accident Investigation	(Month, Day, Year)	INJI		RK? /ES 2 NO				
ATTENDIP ECTOR AL 1 after de 1 28 is 1	8	3 Suicide 6 Could not be 4 Homicide datermined	28a. PLACE OF INJURY building, etc. (Speci	— At home, tarm, s	treet, factory, offici		281. LOCATION (Stree City or Town, State	et and Number or te)	Rurel Route	Number,
PSTAL OR EVAL DIRE In 72 hour T. If then	COMPLET	29a. CERTIFIER (Check only ontal) 2 MEDICAL EXAMIN	SICIAN: To the best of my knowle	edge, death occurre	d at the time, data	and place, and due	to the cause(a) end m	enner as stated.	euse(e) end	manner ee stated.
TO THE HOSPI TO THE FUNER ON THE WITHIN	BE	29b. SIGNATURE AND TITLE OF CERTIFIE MI challe	ER Pintal	2 200	2_	D-211		29d. DATE S		th, Day, Year)
	0	30. NAME AND ADDRESS OF PERSON W Michael C. Pis	stile IMD	2112 F	Print) St NU	1 NDC	20037			
		SEP 2 9 1995	12, REGISTRAR'S SIGNA	Rardalli						

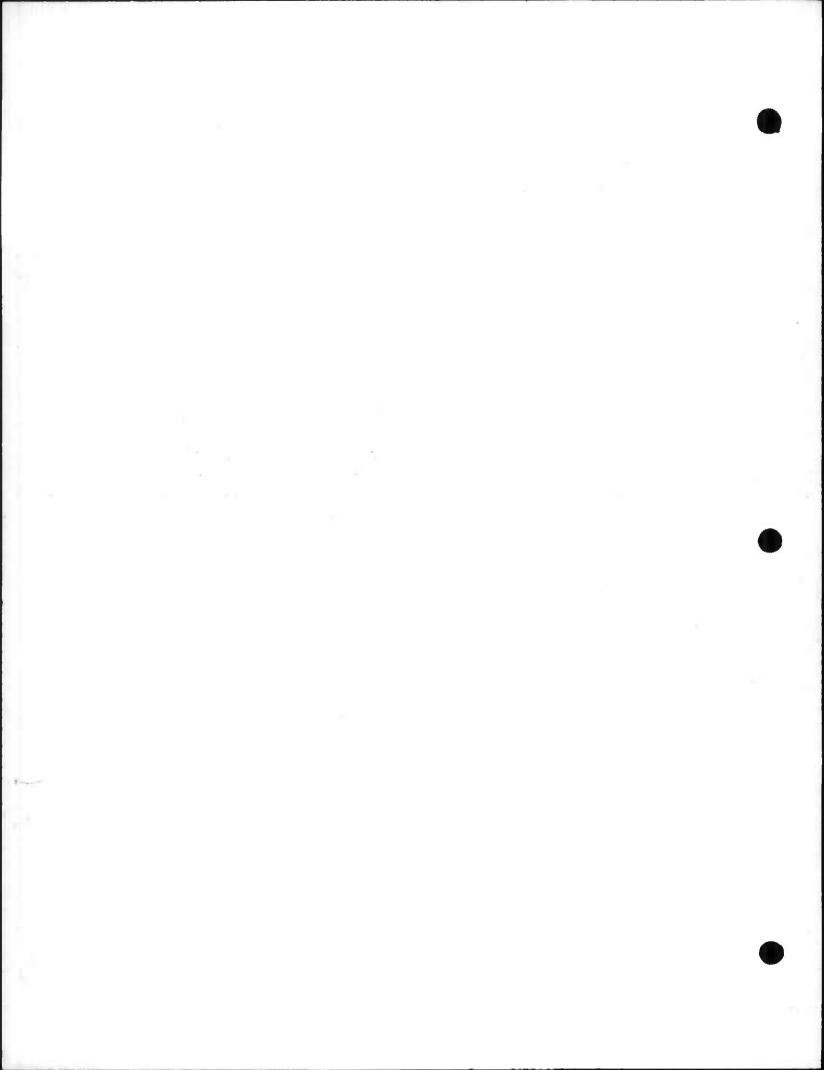


DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the broadel or attending to attending the state of the property of attending the property of the property of attending to attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending to attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property of attending the property	BALTIMORE, MARYLAND 21215-0020
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buniating by the buniating b	our ray or reamed by the hospital or attending physical funeral director, page 5 should be detached for use as the bunial-t

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

Ida L. Moody September 29, 1995 O	NSIDE CITY IMITS? YES 2 NO DUNTRY?						
4. SOCIAL SECURITY NUMBER 214-74-1953 1	(State or Foreign nd visible city imits? yes 2 No Duntry? ericen Indian, , etc.						
214-74-1953 1 M 2 K) F 96 VRS. WONTYIS DAYS HOURS MIN. (Morth, Dey, Bear) PORT MONTY MAN. (If not institution, give street and number) 9a. FACILITY NAME (If not institution, give street and number) 9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home Residence of Decedent 10a. STATE 10b. COUNTY Maryland Cecil 10c. CITY, TOWN OR LOCATION Rising Sun 10d. INS LIM 1 VES 2	NSIDE CITY IMITS? YES 2 NO DUNTRY?						
Calvert Manor Nursing Home Rising Sun Cecil Rising Sun Cecil 106. STATE 108. STATE 109. CITIZEN OF WHAT COLUDE 1109. C	IMITS? YES 2 NO DUNTRY? ericen Indian,						
RESIDENCE OF DECEDENT 10e. STATE 11e. STATE 11e. ST	IMITS? YES 2 X NO DUNTRY? ericen Indian,						
106. STREET AND NUMBER 1881 Telegraph Road 107. ZIP CODE 21911 108. CITIZEN OF WHAT COL U.S.A. 11. MARITAL STATUS 1 Never Married 2 Married 1 Nev	IMITS? YES 2 X NO DUNTRY? ericen Indian,						
10e. STREET AND NUMBER 1881 Telegraph Road 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) Charles C. Queck 10e. STREET AND NUMBER 10f. ZIP CODE 2 1911 10g. CITIZEN OF WHAT COL U. S. A. 11. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 11. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 11. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, a specify Cuban, Maxican, Puerto Rican, etc.) 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. MOTHER'S NAME (First, Middle, Makiden Surname) Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) Charles C. Queck 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code) 246 Mackall Street — Elkton, MD 21921	MITS? YES 2 X NO DUNTRY? ericen Indian,						
Specify: Wh: Spec	ericen Indien, , etc.						
Specify: Wh: Specify: Wh: Speci	, etc.						
P. Gaylord Moody, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Mackall Street - Elkton, MD 21921							
19a. INFORMANT'S NAME (Type/Print) F. Gaylord Moody, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Mackall Street - Elkton, MD 21921							
19a. INFORMANT'S NAME (Type/Print) F. Gaylord Moody, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Mackall Street - Elkton, MD 21921							
19a. INFORMANT'S NAME (Type/Print) F. Gaylord Moody, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stein, Zip Code) 246 Mackall Street - Elkton, MD 21921							
F. Gaylord Moody, Jr. 19b. MalLing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Mackall Street - Elkton, MD 21921							
20a METHOD OF DISPOSITION							
20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of campetery, crematory or other piace) Betnet Cemetery 100 IE3 20c. LOCATION - City or Town, State 100 IE3 Chesapeake City							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACH ITY	y, rib						
Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-							
ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CORONARY ANTRY DISEASE DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MITTUD SUGM TIL CAMBIOV IS CHIPPED MISSENSE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AU	AUTOPSY FINDINGS						
1 TYES 2 NO COMPLET							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	ES 2 NO						
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
1 YES 2 NO 1 Institute 2 ER/Outputlent 3 DOA 4 Murphin Mores 6 Registeres 6 Other (County)							
27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 VES 2 NO							
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26b. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)	mber,						
29a. CERTIFIER (Check only one) 29a. Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.							
2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and mon							
20 SIGNATURE AND THE DESIGN OF THE DESIGN OF EXAMINENT OF THE DESIGN OF INVESTIGATION, IN MY OPINION, death occurred at the time, data and place, and due to the cause(e) and men							
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D. P. J. W.) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER DO 7 463	-95						
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D. T. L.L.) 29d. DATE SIGNED (Month, D. T. L.L.)	-98						



	REGISTRAR		CERTIFICA	TE OF DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)	^ /	1.14	2 1	2. DATE OF DEATN		3. TIME OF DEATN	
	JOSSDH	ALLEN	M	- Non!	MONTH	MY Q YEA	3:20 a.m	
- 1	4. SOCIAL SECURITY NUMBER	7,000	rrs. last birthday) IF UN	DER 1 YEAR # UNDER 24 HRS.	10 0	4 13	-	
	(TO T	1 X M 2 🗆 F	MONTH		7. DATE OF BIRTH (Month, Day, Year)		RTHPLACE (State or Foreign untry)	
	517-09-6106A		3 YRS.		127	1 10	ASH. D.C.	
	9a. FACILITY NAME (If not institution, give str	reet and number)	9b. C	ITY, TOWN OR LOCATION OF	DEATN	9c. COUNTY O		
ı g	Westminson	Nursing 1	Cester 1	1/2000	- TPD	(00	12-01	
DIRECTOR	RESIDENCE OF DECEDENT	190012100	Colik	ucs min	STER	CAI	110011	
	10a. STATE 10b. COUNTY		10c. CITY TOW	N OR LOCATION			10d. INSIDE CITY	
1 =	MA CO	20-00	1.0	A-			LIMITES A	
	146	41000	we	250Mills			1 TES 2 HO	
	10e. STREET AND NUMBER	1 (10f. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	
FUNERAL	1.234 WASH	are tran	120	21157		64	2-1	
Z	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.	SARMED	OC () ST			230	
II.	1 Never Married - Married	FORCES? 1 YES 2	2 NO	3. WAS DECENDENT OF NISP/ If yes, specify Guben, Mexic			ACE — American Indian, lack, White, atc.	
B	3 ₩Idowed 4 □ Divorced	IF YES, GIVE WAR OR OATE		1 TES 2 NO Spec	tty:	S	quality: p	
		TOW IT WATE	(Jupap)			1 4	mute:	
100	15. DECEDENT'S EDUC (Specify only highest grade of		a. DECEDENT'S USUAL	OCCUPATION ne during most of working	16b. KIND OF BU	SINESS/INDUSTR	1	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retired	ne during most or worlding				
립	12		and	1 22	July .	- 11-	201.00	
COMPL	17. FATHER'S NAME (First, Middle, Last)		relieuw 15		-CNR	2 10	TICI NES	
examiner must be notified at once. TO BE COM	C Prisi, Milder, Lase	e I		18. MOTNER'S N	AME (First, Middle, Maider	Sumame) Λ	4	
삞뻍	he kay	Deal		8L120	PETO	AU	en	
E 0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRI	SS (Street and Number or Rura	Route Number, City or Tox	vn. State. Zip Code)		
틸	MUANY TABE T	20.00	3590 0	Dines Cl i	11/2-	- e 1.	12,-2	
9	20a. METHOD OF DISPOSITION	Cresc		THORN CT, U	UESTIMINS.	11/10	J/15 T	
<u> </u>	1 Burial 2 Cremation 3 Remo		ACE AND DATE OF DISP ry, cremetory or other place		OATE 20c. LO	OCATION — City or	Town, State	
E	4 Donation 5 Other (Specify)		trood C	Remertion	caz H	STRANGE	AD. 116	
Ē	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	2	2. NAME AND ADDRESS OF F	ACILITY			
툲	1 17/10/					00	In ALA	
	1.64	X som	7	PUTE FIL	412 WAS	4 40 1	Describertal	
20	23. PART I. Enter the Gleenses, or co	omplications that caused th	e death. Do not ent	er the mode of dying, su	ch se cardiac or resc	iratory arrest.	Approximats	
Ě	anock, or neart failure. L	lat only one cause on each	Ilne.				interval Between	
2	IMMEDIATE CAUSE (Final disease or condition						Onset and Death	
3		Aspiration	nneumon	ia			3 days	
N.		Aspiration OR AS A CO	INSEQUENCE OF):					
any injury, or other traumatic event, the medical		Dysnhasia					1987	
ry, or other traumatic CERTIFICATION	Sequentially list conditions, If any leading to immediate b. Dysphasia DUE TO (OR AS A CONSEQUENCE OF):						150,	
\$ Z	cause. Enter UNDERLYING Cerebral Vascular accident						1987	
희윤	CAUSE (Disease or injury	DUE TO (OR AS A CO						
e E	that initiated events resulting in death) LAST	(011 70 7 00	MOLOGENOE OF J.				11711	
9 6	d.							
	PART II. Other significant conditions	contributing to death but a	not mondition to the	and the fact of the second second	T			
EDICAL	a ditti signituani conditions	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? AM						
					1 TYES	ON X	COMPLETION OF CAUSE	
S							OF DEATH?	
S ≥	DID TOBACCO USE CONTR	IDLITE TO CALISE OF F	SEATU VEC T	NO D UNICEPTAL			1 [] YES 2 [] NO	
8 8	25. WAS CASE REFERRED TO MEDICAL				иП			
YSICI	EV LIMITEDO	HOSPITAL:	PLACE OF DEATH (Che					
2 2		1 Inpatient 2 ER/Outpatier	nt 3 DOA 4 D	ursing Nome 5 Residence	8 Other (Specify)			
티토	27. MANNER OF DEATN	28s. DATE OF INJURY	28b. TIME OF	28c, INJURY AT	28d. DESCRIBE HOW	INJURY OCCURED		
g 0	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WORK?				
BY	2 Accident Investigation							
Z8 IS marked, TED BY PH	3 Suicide s Could not be	28a. PLACE OF INJURY — I building, atc. (Specify)	At home, farm, street, fo	actory, office	28f, LOCATION (Street City or Town, State	and Number or Run	al Route Number,	
COMPLETED	4 Homicide datarmined							
	29a. CERTIFIER 1 X CERTIFYING PHYSIC	IAN: To the best of my knowledge	o death assumed at th	Mary day to be a second at		· · · · · · · · · · · · · · · · · · ·		
= =	(Check only one) 2 MEDICAL EXAMINED	On the heale of eventeets	dies les ettentions	unite, care and place, and du	v to the cause(s) and ma	nner sa stated.		
	mediate examiner	: On the basis of exemination and	d/or investigation, in m	opinion, death occured at the	s time, data and place, as	nd due to the caus	e(a) and menner as stated.	
	29b. SIGNAPOTE AND TITLE OF CERTIFIER			29c, LICENSE NU	MBER	29d. DATE SIGN	ED (Month, Day, Year)	
Z 00	1 7/201	3/		Dl	7040		02-95	
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) /Tona Datast					
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						
1	215 Washington Hgts Med Ctr, Westminster, MD 21157							
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE							
	UUI U5 1995 July Davidson Kardall							

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MARY	
BALTIMORE,	
BOX 68760	
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DIVISION OF VITA

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31. DATE FILED (Month, Day, Year)
OCT 05 (1995)

30/NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE

6

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ND 21215-0020

Pages 1, 2, 3 permit. use as the burial-transit the hospital or attending physician. ay be retained by the hospital or page 5 should be detached for 智 notified pe Page 6 may must funeral director, examiner in by the fi medical in by 8 npletely fille cremation, the event, burial, traumatic and 2 attending physician antal Hygiene prior to other the atten Injury, 30 any Health a shows t. of h OR ATTENDING PHYSICIAN: The law I DIRECTOR: After this certificate has be hours after death with the State Dept. 23 tem 10 marked, 60 28 Hem FUNERAL WITHIN 72 h HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

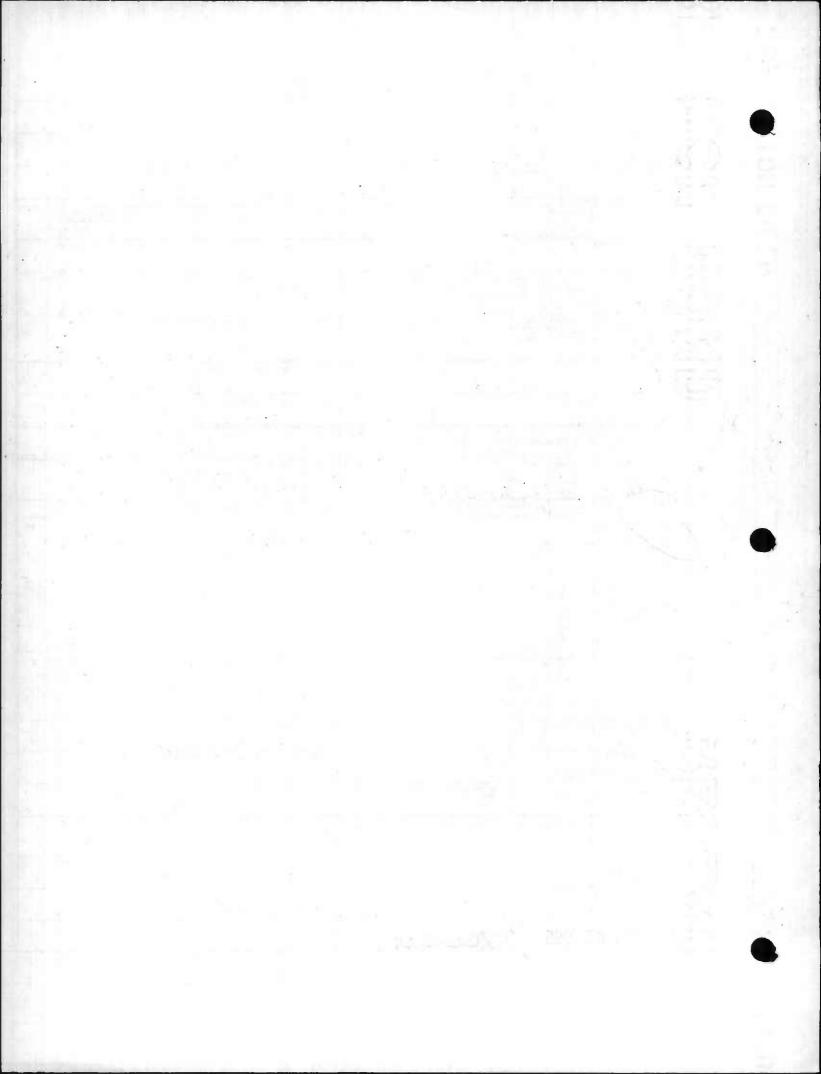
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Helen Ruth Moore 1995 Oct. 7:58 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 1 M 2 F 79 Oct. 247-05-1829 10. 915South Carolin Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 529 Baltimore Annapolis Blvd. Severna Park Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel 1 TYES ZYNO Severna Park FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 529 Baltimore Annapolis Blvd. 21146 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU OF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 TES 2XXNO Specify Specify: BY 3 🔀 Widowed 4 🗌 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12+ ARA Food Services 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Andrew Jackson McKiney Addie Lee Corn BE 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 19a. INFORMANT'S NAME (Type/Print) 21146 2 Connie Evans 529 Baltimore Annapolis Blvd. Severna 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION - City or Town, State 208. METHOD OF DISPOSITION

1 Burial 27 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Crematory 10-04-1995 Baltimore, Marylan 21. SIGNATURE OF JUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 495 Ritchie Hwy Severna Pk, MD 2114 28. PART I. Enter the diseases, or complications that caused the desapeth, or heart fellure. List only one cause on each line. inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between IMMEDIATE CAUSE (Final **Onset and Death** Lyeast disease of condition resulting in deeth) 5 1/2 Years DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (DR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 - YES 2 - NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
4 □ Nursing Home 5 Residence 6 □ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 26c. INJURY AT-WORK? 1 YES 2 NO 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation BY 3 Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and piscs, and due to the cause(s) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the films, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

OHMH-16 Rev 1/89

Annapolis



YEAR

Conn

10g. CITIZEN OF WHAT COUNTRY?

1995

9c. COUNTY OF DEATH

AA

USA

1927

3. TIME OF DEATN

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

MD21146

Interval Batween Onset and Death

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 T NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

9-25-1995

21035

1 YES 2 X NO

B. BIRTHPLACE (State or Foreign Country)

2230

REG. NO

2. DATE OF DEATN

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Charles

MacGuire

Gerald

31. DATE FILED (Month, Day, Year)

OCT 05 1995

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24 Sep 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year HOURS 17 M 2 | F 68 047-16-2511 Oct 06 use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 803 West Benfield Road Severna Park RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Anne Arundel Severna Park 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 803 W. Benfield Rd. 21146 retained by the hospital or attending physician. 5 should be detached for use as the burial-trar 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) FORCES? 1 YES 2 1 Never Merried 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 X Divorced Korean War COMPLETED 18e. DECEDENT'S USUAL OCCUPATION

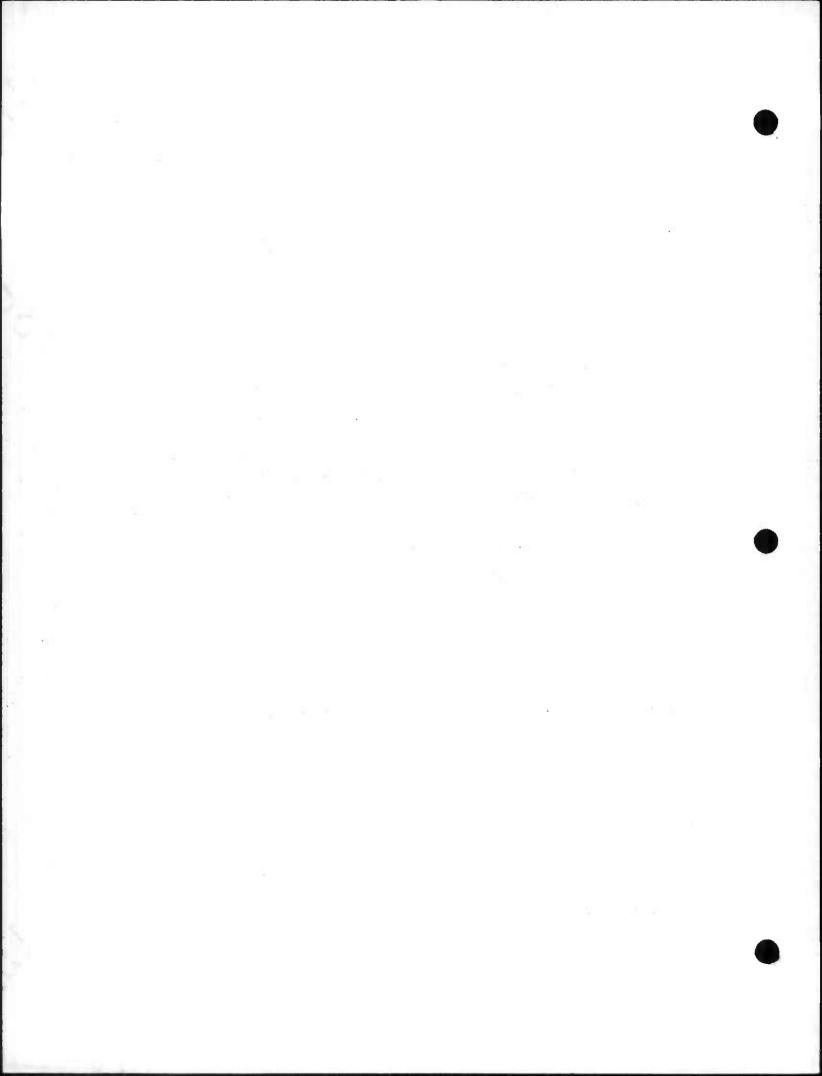
(Shan kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Marketing Executive Sales 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surneme) Ħ Gerald BE MacGuire. Elizabeth Weadick notified a page 5 should 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 James MacGuire 7350 Windsor Drive Boulder CO 80301 nours after death. Page 6 may be pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must funeral director. 4 Donation 5 Other (Specify) Metreo Crematory 9/27 Catonsvile, MD 21. SIGNATURE OF FUN MAL SERVICE LICE examiner 22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 495 Ritchie Hwy Severna Park completely filled in by the ial. cremation, or removal. medical 23. PART VEnter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. ahock, or heart failure. List only one ceuse on each line IMMEDIATE CAUSE (Finel the disease or condition Acute Cardiac Insufficiency event, DUE TO (OR AS A CONSEQUENCE OF): in and comp executed ASCVD traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING attending physician 8 Hygiene prior death certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 signed by the atter Health and Mental I in uny, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 計 MEDICAL requires that any 1 YES 2X NO shows 2 peen 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖸 NO 🗆 PHYSICIAN: Dept. 3W 23 this certificate has with the State Dep 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATN (Check only one) Hem HOSPITAL: OTHER YES 2 NO HOSPITAL DR ATTENDING PHYSICIAN: 1 | Inpetient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 XResidence 6 Other (Specify) 10 the 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, INJURY 1 X Natural 5 Pending investigation 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d item 28 is 80 COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the filme, data end place, end due to the cause(s) and manner as stated. FUNERAL (= 2 🔯 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CENTS 29c. LICENSE NUMBER BE Deputy D 06054 0 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, M.D. 695 America Ct.

32. REGISTRAR'S SIGNATURE

Davidson Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

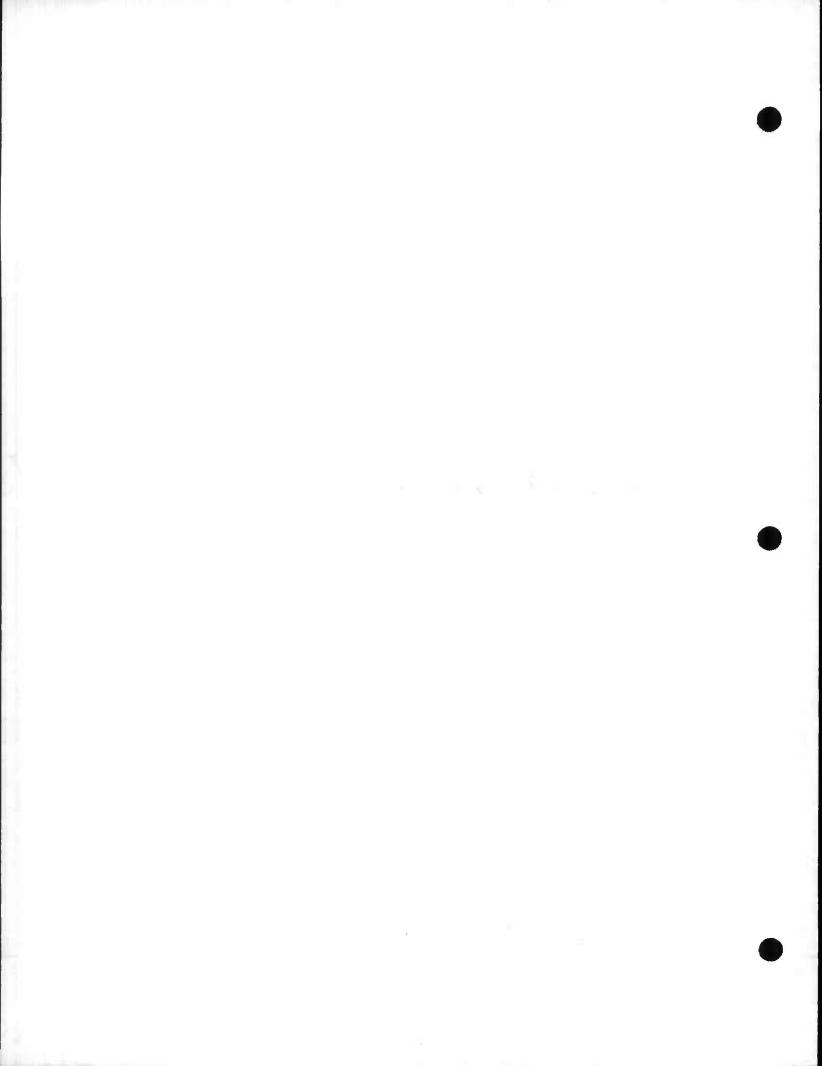
DHMH-16 Rev 1/89



		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last)	Last		na://a		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE (In y	rs. last birthday)	IF UNDER t YEAR	IF UNDER 24 HRS.	SEPT . 2	5 1995	1PLACE (State or Foreign
P			ZW10 F 56		MONTHS DAYS	HOURS MIN.	Dec 1, 193	39 Course	Fa State of Foreign
3 should	E	PENINSULA REGIONAL				SBURY	EATH	9c. COUNTY OF D	
s 1. 2,	בַּ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							
permit. Pages	DIRECTO		omics	F 10c. CITY,	TOWN OR LOCAT	nd			10d. INSIDE CITY LIMITS? 1 YES 2
sit	FUNERAL	P. D. BOX 81)				ZIP CODE	ío .	10g. CITIZEN OF V	WHAT COUNTRY?
physician. burial-transit	S	11. MARITAL STATUS 1:	2. WAS DECEDENT EVER IN U.S				NIC ORIGIN? (Specify Yes	s or No — 14. RACI	E — American Indian,
2 g 4	BY F	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES 2	S		2 ANO Specif	n, Puarto Rican, etc.) y:	Speci	k, White, etc. HY: Black
	뎶	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION 16	e. DECEDENT'S U	SUAL OCCUPATION MONTH OF THE PROPERTY OF THE P		16b. KIND OF BU	SINESS/INDUSTRY	
. 0 .	COMPLET	Elementary/Specyndary (0-12)	College (1-4 or 5+)	Ampl	Bell So	шр	Comp	shell So	up
by the hospital be detached to at once.		17. FATHER'S NAME (First, Middle, Last)	1/2			18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)	
retained by 5 should be notified at	BE	t9a. INFORMANT'S NAME (Type/Print)	113	19b. MAILING A	OORESS (Street a	nd Number or Burel	Boulte Number City or Type	m State Zin Coffee	
. 5 6 6	임	Bernice Mill	5	P.O	. Box	011 1	u. Hand	ma, z	1826
15 pt 15 pt		20a, METHOD OF DISPOSITION 1		ACE AND DATE OF		metary	9/30 SA	LISBURY	mn, State
		21. SIGNATURE OF PANERAL SERVICE LICEN			22. NAME AN	D ADDRESS OF FA	CILITY	THVERA	1 Home
	, Y	1618 West Rd. Salisbury, W							uy, md.
ours after d in by the or removal		23. PART I. Enter the diseases, or con shock, or heart failure. Lie	iplications that caused the t only one cause on each	e death. Do no line.	t enter the mo	de of dying, suc	h as cardiac or reapi	iratory srrest,	Approximata Interval Between
Pe on File		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Resi	rivita	1 5	Juli			Onset and Death
ted within completely ial, cremati, event, t		a	DUE TO (OR AS A CO	NSEQUENCE OF)	1	. 00			07
and and bur	CATION	Sequentially list conditions, if sny, leading to immediate	DUE TO TOR AS A CO	MEGUENCE OF):		0 (1)			Vars
ficate be physician ne prior b		csuse. Enter UNDERLYING CAUSE (Disease or Injury							
Hygie of the	RTIF	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):					
0 00 5	CE	PART II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying	Cause alven la	Part I. 24s, WAS AN	ALPPARAY TOU	WEST 4123224 EVENTS
	ICAL		grania.	900	- 00	PRen	PERFOR	PMED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE
w requires that been signed by pt. of Health an 3 shows any	MEDIC			5	,Co	\		X	OF DEATH?
2 8 8 a	AN:	DID TOBACCO USE CONTRIB				UNCERTAIN	v 🗆		
£ 88 F	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1	OSPITAL: Inpetient 2 - ER/Outpetier		OTHER:				
PHYSICIA this certif with the fed, or	PHY	27. MANNER OF DEATH	26s. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 26c. INJU		6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED	
DING PHYS After this death with	ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 7	ES 2 NO			
TTEN TOR: after	回	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, str	eet, factory, office	,	281. LOCATION (Street a City or Town, State)	and Number or Rural R	loute Number,
DIR Hour	COMPLET	29e. CERTIFIER (Check only	N: To the best of my knowledge	e, death occurred	at the time, date	and place, and due	to the cause(s) and man	nner as stated.	
HOSPITAL FUNERAL WITHIN 72 TANT: If	SON		On the basis of examination and	d/or Investigation,	In my opinion, de	eath occured at the	time, data and place, an	d due to the cause(a) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CERTIFIER	n wil			29c. LICENSE NUM	BER 35	≥ Q Z	(Month Day 1907)
	유	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF OEATH	(ITEM 27) (Type) P	rint) A	Cl	Sun Ilr	1 71	Poi
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	1	COV /	1 Rus	700		()
10		SEP 27 1995	32. REGISTRAR'S SIGNATUR JULIA D'AUNCLEAN	tardall					

			FOR STATE REGISTRAR	STATE OF MA	RYLAI	ND / DEPARTMENT CERTIFICATION	T OF H	EALTH AND	MENTAL	HYGIEN REG. NO			
			1. DECEDENT'S NAME (First, Middle, Last)		_				2. DATE O	F OEATH		3	3. TIME OF DEATH
•			FREDA	M		McGEI	E		Sept		2	L995	1:15A
Ð			4. SOCIAL SECURITY NUMBER 215-07-6804	5. SEX 6.	AGE (In :	***********	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE O (Month, OCTOD	F BIRTH Day: Year PT 17,	1911	Country)	LACE (State or Foreign
3 should		~	9a. FACILITY NAME (If not institution, give st					OR LOCATION OF D			9c. COUN	Y OF OEA	тн
1, 2,		DIRECTOR	Salisbury Nursi		ab						WIC	OMICO)
permit. Pages			-	timore		Balt:	imor	e					IOd. INSIDE CITY LIMITS? YES 2 NO
15		FUNERAL	100. STREET AND NUMBER 1112 Newfield F					2 1 2 0 7			US		AT COUNTRY?
LAND 21215-0020 the hospital or attending physician. detached for use as the burial-transit		B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES	S (ZKNO	If yes, sp	ENDENT OF HISPAI ecity Cuban, Maxica 2 XNO Specifi	n, Puerto Ric	(Specify Yes	or No-	4. RACE - Black, V Specify: Whit	
21215 al or attend for use as		TED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	-10	6e. DECEDENT'S USUAL O	durina ma	ON st of working	16b. I	CIND OF BU	SINESS/INDU		
ID 27	_	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	S	ite. Do NOT use retired.) Seamstress				Coat	facto	ory	
LAND the hospit detached	Once.	00	17. FATHER'S NAME (First, Middle, Last)	W:11			***	16. MOTHER'S NA	ME (First, Mic	ddle, Maiden	Surname)		
MARYLAND retained by the hospit 5 should be detached	ed at	BE	Archie	Mill	er			Anna			(unkı		
MAR retained 5 should	notified	၉	190. INFORMANT'S NAME (Type/Print) Gordon Sullivan			196. MAILING ADDRESS		. St., De					
BALTIMORE, hours after death. Page 6 may be ed in by the funeral director, page	must be		20a. METHOD OF DISPOSITION 1 □ Burlel 2 🛣 Cremation 3 □ Remo	oval from State	20b. PI	LACE AND DATE OF DISPOS	SITION /Na		DATE	20c. LO	CATION — C	ty or Town	
MC direct			4 Donalion 5 Other (Specify)	ENCEE	Sal	ry, grematory or other place)	-		9/25	Sa	lisbu	cy, N	4D
BALTIMOR lor death. Page 6 ma the funeral director, p	examiner		O P STATE OF THE SERVICE LIC	1000				oway Fur		Home			
BA fler de	is e	\dashv	won v	BULLOW	de		501	Snow Hil	1 Rd.	, Sal	isbur	y,MD	21801
A hours aft	medical		23. PART I. Enter the diseases, or c shock, or heart fellure. I	lat only one course	on bed	death. Do not enter line.	the mo	de of dying, auc	h aa cerdle	c or reap	ratory arre	nt,	Approximata Interval Between
A 章		1	IMMEDIATE CAUSE (Finel disease or condition	Con	7200	True il	ONE	1 Fail	7,40				Onset and Death
68760 executed within and completely	event, the	1	resulting in death)		_	ONSEQUENCE OF):	-77	· · · · · ·					Johns
X 68760	0	S	Sequentially list conditions,			DISEQUENCE OF):	an						
Cian of	or other traumatic	Ĕ.	If any, leading to immediate cause. Enter UNDERLYING	DUE 10 (OF	I AS A C	ONSEQUENCE OF):							
O. B. certificate ding physi	ther		CAUSE (Disease or injury that initiated eventa	DUE TO (OF	AS A CO	ONSEQUENCE OF):							
DS, P.O. B the death certificat the attending phy		CERTIFICATION	resulting in death) LAST										
DS, P the death the atten		ا د	PART II. Other algnificant conditions	contributing to de	eth but	not resulting in the ur	nderlying	cause given in	Part I. 2	4a. WAS AN		246. W	ERE AUTOPSY FINDINGS
OR of that	amy	절	Aprianced 1	Denalco					_ ,	PERFOR		C	VAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?
REC equire	23 shows an	MEDIC	Emplyse			errus							YES 2 NO
AL RECORDS he law requires that the calculations has been signed by the	23 \$	Ä	DID TOBACCO USE CONTR	IBUTE TO CAUS				UNCERTAIN	1 🗆				
FFai	Item	PHYSICIAN:	EXAMINER?	HOSPITAL:		PLACE OF DEATH (Check	Rt:	e 5 🗆 Residence	* D 000	0			
F % 8 ;	d, 04	춫┃	27. MANNER OF DEATH	26s. DATE OF INJ (Month, Day,	URY	28b. TIME OF INJURY	28c. INJ	URY AT			NJURY OCCU	RED	
ON O DING PHY	- 36	8	1 Naturat 5 Pending 2 Accident Investigation	(Month, Day,	rour,	M		RK? 'ES 2 NO					
	28 Is		3 Suicide 6 Could not be determined	28s. PLACE OF IN building, atc.	JURY (Specify)	At home, farm, street, fact	tory, office		261, LOCAT City or	ION (Street a Town, State)	nd Number o	Rural Roul	te Number,
			29a. CERTIFIER (Check only	IAN: To the best of my	knowled	ga, death occurred at the t	ime, data	and place, and due	to the cause	(a) and man	ner as stated		
HOSPITAL		COMPLE				nd/or investigation, in my o							nd menner as stated,
THE HOSPI	P (00)	w I	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUN					Ionth, Day, Year)
5 5 7	N N	0	- h	a a	w			D-39813			•	7/2	2/98
			30. NAME AND ADDRESS OF PERSON WHO										
			MICHAEL ATKINS, M.	D.,1104 H	EALT	HWAY DR., SA	LISE	BURY, MD.					

SEP 25 1995



TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed with the foath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Ilem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

	REGISTRAR		CE	RIIF	CATE OF	DEATH	RE	G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D			3. TIME OF DE	ATH
	Irene	M. Morgan					Octobe	or / 19	995	12:20	2 M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI			HPLACE (State or	
	212-26-3139	1 M 2 X) F	67		MONTHS DAYS	HOURS MIN.	(Month, Day.	Year)	Count	try)	
	9e. FACILITY NAME (If not institution, give	etmet and number)	9,		AL 0474 TOWN		Dec. 7		_	nsylvani	.a
C						OR LOCATION OF D	EATH		UNTY OF E		
2	Edw.W.McCready M	emorial Ho	spital		Crisf	ield			Some	rset	
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY	TOWN OR LOCAT	TION				10d. INSIDE CIT	rv.
1 %	Maryland So	omerset			Crisfi					LIMITS?	
	10e. STREET AND NUMBER	MICISCO		_						1 TYES 2	
FUNERAL					101	. ZIP CODE	_	10g. CI		WHAT COUNTRY?	
빌	4247 Hill Lane					2181				S.A.	
문	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT E FORCES? 1	VER IN U.S. ARM YES 2 TONO	ED)	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Spi	ecity Yee or No-	14. RAC	E — American Inc k, White, etc.	Hen,
l Mari	3 Widowed 4 Divorced	IF YES, OIVE WAR	OR DATES			2 NO Specif			Spec	effy:	
]	100		1				<u> </u>	White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16e, DEC	EDENT'S U	SUAL OCCUPATION wk done during mo retired.)	ON est of working	16b. KIND	OF BUSINESS/IN	IDUSTRY		
اتا	Elementary/Secondary (0-12)	College (1-4 or 5+)					1				
₹	Grade 9		Hous	sewif	е			ome			
8	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle,	Maiden Surname)			
H	Elmer Dietz					Iren	a Mae F	ortney			
0	19e. INFORMANT'S NAME (Type/Print)					and Number or Rural			(ip Code)		
F	John G. Morgan (H	Husband)	4	1247	Hill Laı	ne – Cri:	sfield,	MD 218	817		
	20e. METHOD OF DISPOSITION 1		20b. PLACE AN	DDATEOF	DISPOSITION (Na	me of	DATE	20c. LOCATION -	- City or Tr	own, State	
1 1	4 Donation 5 Other (Specify)	IOVAI ITOM SUME	Salish	etory or oth	er place) Crema to:	ry - 10/4	4/95	Salis	ourv.	MD	100
1 1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		1	22. NAME AN	D ADDRESS OF FA	CILITY			1110	
1 1	Select 12 13	lacks	exel		Bradsl	haw & Son	ns Fune	ral Home	9		- 1
-	Robert H. Bra	dshaw, Jr.			306 W	. Main S	t Cri	sfield,	MD	21817	
	23. PART I. Enter the diseases, or ahock, or heart fallure.	complications that co List only one cause	on each line.	th. Do no	t enter the mo-	da of dying, auc	h aa cerdlac o	r reapiratory a	rreat,	Approxim	
	IMMEDIATE CAUSE (Final	11	2.17			10/11	0 -			Onset ar	
	disease or condition resulting in death)	· HE	PHT	10	1	7/14	RE			1100	1/4
	,	/ DUE TO (DE	AS A CONSEOU	JENCE OF		111	-	, ,		4.1	
z		· CIK	RHO	91	9 01	the !	110	ER		2/2	oss
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OF	AS A CONSEQU	ENCE OF	-4	- 15	- 1			1	
3	cause. Enter UNDERLYING CAUSE (Disease or injury	· HNG	4611	NI	PPE	NDEU	T DI	AKET	25	Yes	ns
E	that initiated events	DUE TO (OR	AS A CONSEQU	ENCE OF			7,				100
E	resulting in death) LAST	4.									
	PART II. Other algorificant condition	os contributios to do	oth hut and mi								
EDICAL	CHINA	7/C	oth but not rea	suiting in	the underlying	cause given in	Part i. 24e.	WAS AN AUTOPSY PERFORMED?	246	. WERE AUTOPSY	
ă	CIKON	70	71/	~//	Ξ / J	<u> </u>	1_	YES 2 NO		COMPLETION OF OF DEATH?	CAUSE
뿔								/)	- 1	1 YES 2	NO
	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	H YES	□ NO X	UNCERTAIL	V 🗆	/			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	/	26 PLACE	OF DEATH	(Chack only one)						
S	1 YES 2 NO	INDSPITAL:	(Outpetient 3 C		OTHER:	s I 🗆 Residence	6 Other (Spec	eller)			
≩	27. MANNUM CHOEATH	JON. DATE OF INJ		28b. TIME	OF 26t INJ	URY AT		HOW INJURY OF	CCURED		$\overline{}$
	1 Natural 5 Pending	(Month, Dep.)	Nat (INJUI		RIK? FEB 2 NO					
BY	2 Accident Investigation	28s. PLACE OF IN	JURY — At home	e, ferm, str			281 LOCATION	(Street end Number	er or Rural i	Boude Mumber	
	4 Homicide 8 Could not be determined	building, etc.	(Specify)				City or Tow	n, Stete)	n or riginit	Youre Hamber,	
9	29e. CERTIFIER										
<u>A</u>	(Check only CENTIFYING PHYS	ICIAN: To the beat of my									
COMPLET	MEDICAL EXAMINE	R: Dn the basis of exam	Ination end/or inv	reatigation,	In my opinion, de	eath occured at the	time, date end p	lace, end due to t	the cause(s	s) end manner ee	stated.
ш	29b, BIGHADURE AND TITLE OF CERTIFIE	0 ///	111		nAx	294 LICENSE NUM	IBER	/ 29d. DA	TE SIGNED	(Month, Day, Year	
B	Harrer H	- X 80	eller	91	(UD)	DIA	214		10-	4-9	5
유	30. NAME AND ADDRESS OF PERSON WH					4 ()	1/		, -	/ /-	
	Dr. James A. S					l, Md. 21	1817				
	31. DATE FILED (Month, Day, Year)	A 32. REGISTRAR'S	SIGNATURE								
	DCT 0.5 1995 John	32. REGISTRAR'S	44								

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	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 yours after death. Pag	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dis
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	OR /	DIRE
	-	

_	1 - STATE REGISTRAR	STATE OF MARYL	CERTIFIC	CATE OF	DEATH AND		EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last					2. DATE OF	DAY	YEAR	3. TIME OF DEATH
	Melvin Matt	7				Sept.			2:40 P
	216-03-9435	1 🛚 M 2 🗆 F	83 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		2-1912	Mar	yland
20	90. FACILITY NAME (If not institution, give Hartley Hall RESIDENCE OF DECEDENT				or location of the			Ces	
DIRECTOR	10a. STATE 10b. COUN Maryland	Somerset	10c. CITY,	TOWN OR LOCA	Crisfiel	.d			10d. INSIDE CITY LIMITS? 1 [X] YES 2 NO
FUNERAL	10e. STREET AND NUMBER			10	M. ZIP CODE		10g. CIT	ZEN OF W	THAT COUNTRY?
	204 Myrtle Stree	t			21	817		U.	S.A.
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	If yes, s	CENDENT OF NISPA pecify Cuben, Mexic S 2 XNO Spec	en, Puerto Ricer		Black	- American Indian, White, etc. White
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	fe completed)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during m	ION lost of working	16b. KIN	D OF BUSINESS/INC	DUSTRY	
	Grade 6	College (1-4 or 8 +)	Contrac	tor		Pa	ainting		
5	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N		e, Maiden Sumame)		
H H	Roland Matthews				Elnor	a Mille	er		
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING A	DDRESS (Street	and Number or Rura	Route Number, C	City or Town, State, Zip	Code)	
	Carolyn Rayfield	(Daughter)	209 1	1th St.	- Pocom	oke Cit	y, MD 2	1851	
- 1	20s. METHOD OF DISPOSITION N Burlal 2 Cremation 3 Re-	movel from State com	PLACE AND DATE OF entery, cremetary or other	DISPOSITION (A	lame of	DATE	20c. LOCATION —	City or To	wn, State
- 1	4 Donation 5 Other (Specify)	St St	mavridge	Memori			Crisf	ield	MD
- 1	21. SIGNATURE OF FUNERAL SERVICE L				ND ADDRESS OF F				
	Robert H. B	Cadebaw T					eral Home		01015
	23. PART I. Enter the diseeses, pr	complications that course	the deeth Do no	t enter the m	ode of dylan su	ch as cardiac	sfield,		21817
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	bDUE TO (OR AS A	CONSEQUENCE OF:		es E Ge	nereli	ied met	star	Onest and Da
	BAST II Oher sleetilees as a dist	d							
: MEDICAL	PART II. Other significant condition arterios cles	interfear Ceplesment (Befor this	t Disea Pigs va Pulms	se; H lue);	y gertens		PERFORMED? YES 2 NO	24b.	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL	- accure	o wins		LACE OF DEATH (C	hack only one)			
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp		OTHER:			San.		
Ē	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIME	-	me 5 Residence		BE NOW INJURY OC	71950	
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ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, stri				N (Street and Number wn, State)	or Rural A	oute Number,
COMPLET		SICIAN: To the best of my knowl ER: On the basis of examination							
- 11	296. SIGNATURE AND TITLE OF CERTIFIE			in my opinion,					
BE	The page 1	7 B.O.	. 2	2	D 200	MBER			(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON W	Me pettos	o my	1	2 29	05	19	-2	9-95
	GREGORIO A	1. BELLOSO	- 442/7		wood !	Z, CR	ISPIELD	MD	218/7
	OCT 0 3 1995	A 32. REGISTRAR'S SIGN	ATURE						

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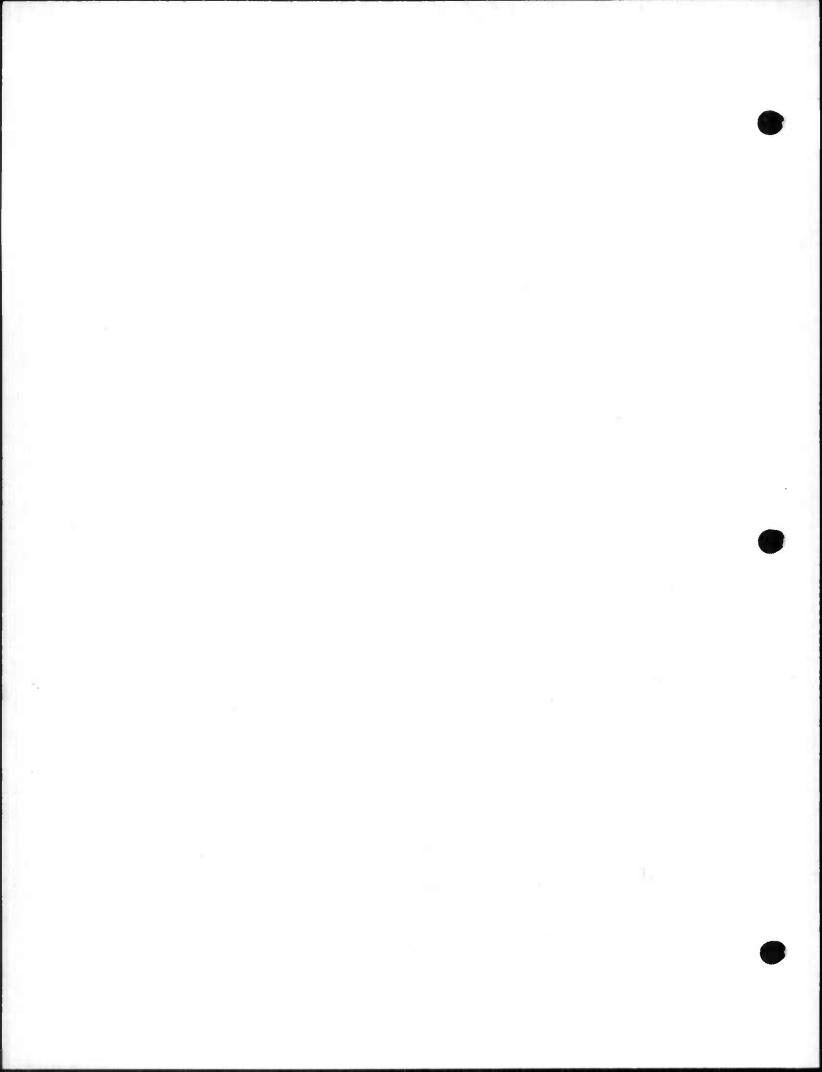
eed by the hospital or attending physician.

wild be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

DALLIMONE, MA	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retain.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shot be filled within 72 hours after death with the State Dest, of Health and Mental Hydriene prior to burial cremation, or removal	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifi-
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0	hours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the its fleed within 72 hours after death with the State Dect, of Health, and Mental Hydiene prior to burial cremation, or remnal	medical
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAL **COLORS SCHOLARS** **COLORS SCHOLARS** **COLORS SCHOLARS** **LOCAL SCHO									9	5 312/4
DECEMBER AMERICAL SUMMALIST Catherine			STATE OF	MARYLAND /	DEPAR	TMENT OF A	EAITH AND	MENTAL HYCIEN	IE.	
Catherine Alverda **SOCIAL SECURIT FORMER **SOCIAL SECURITY ROBARC		REGISTRAR		CE	RTIF	CATE OF	DEATH			
BY SOCIAL SECURITY NAME (PICE ALONG ALONG ASSOCIATION OF A SAME AND A STATE AND ADMINIST AND ADMINISTRATION OF A SAME ADMINISTRATION OF A SAME ADMINISTRATIO		The second secon		A 7 an				MONTH D	AY	YEAR
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Secondary Seco			rederick						T 40+ 017/3	
Secondary Seco	ERA	2604 New Design	Road							
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Sequentially list conditions Sequentially list conditions	B					1 🗆 YES	2 NO Specif	y:		Snecthr
ROBERT Lee Tabler Tabler The Maling address (Street and Number or Numi Place Number, City or Stem, Stein, 26 Code) Mr. Eugene E. Mills, Jr. 2604 New Design Road, Adamstown, MD 21710 260, METHOD OF DIRECTAL STEP STEEL CARROLL AND ALTE PROPERTY OF THE	윤	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Gh	re kind of v	vork done during mo	ON ast of working	16b. KIND OF BU	SINESS/INDU	JSTRY
ROBERT Lee Tabler Tab	PLE		College (1-4 or 5	+) ///0.	Do NOT us	e retired.)		Home		
ROBERT Lee Tabler Tab	WO	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle, Malden	Surname)	
The Machina address gives and number or found humber of plant how Number, City or Sem. State. 20 Cody) The METHOD OF REPORTION. The METHOD OF REPORTION IN PROPERTY OF THE P			ee Tabl							
Martel 2 Commention 3 Removat from State Commention 3 Commention 5 Co			ls, Jr.							
21. SIGNATURE OF PUNETAL SERVICE LICENSEE ADDITION ADD		1 M Burlet 2 Cremetion 3 Remo	vat from Stata	20b. PLACE A cemetery, cren FORES	nd DATE O	proisposition (Ne	rv. Oct.	2.1995 Ga	cation – c	Shure. Maryland
23. PART I. Enter the Bissesse, or complications they suised the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervised between conditions and post to complications they suised the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervised between conditions and post to conditions and post to conditions. But to conditions and post to conditions and post to conditions. But to conditions and post to conditions and post to conditions. But to conditions and post to conditions and post to conditions. But to co		21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	1		22. NAME AP	ID ADDRESS OF FA	CILITY		
23. PART I. Enter the diseases, or complications they found the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart feiture. List only one cedde on each line. Approximate shock, or heart feiture. List only one cedde on each line.	3	Allan 9	+ Ru			106 E	Church	St., Frede	rick.	MD 21701
disease or condition resulting in death) BUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF):		snock, or heart fellure. L	omplications the lat only one cer	sused the decise on each line.	eth. Do n	ot enter the mo	de of dyling, suc	h ss cardisc or resp	iratory srre	Interval Between
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HIPGRIE AS AN POLYCYTHOM 14 ARXIVE FIBRILLATION YES 2 PHO PERFORMED? 1 YES 2 PHO CONPLETION OF CAUSE OF DEATH? 1 YES 2 PHO THE 1 YE		- 0								
Natural 2 Accident	SA S					and the same		PERFOR		AWAILABLE PRIOR TO
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Natural 2 Accident	HYS					4 - Nursing Hom			HILIBY OCCI	IREO
3 Suicide 4 Homicide 5 Could not be detarmined 288. PLACE OF INJURY — At home, farm, street, factory, office 298. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Do the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. Andrew 0. Done 1 Son M.D. 915 To 11 house Avera Suite 203 Freedows of the cause (a) and menner as stated.		A				OW YPU	RK?	IN DESCRIBE NOW P	NJUNT OCC	JAED
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Vear) Sept 29, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew 0. Done 1 Son M. D. 915 To 11 hourse Average Suite 203 Freedomick MD 21 701		3 Suicide 6 Could not be	28a. PLACE C building,	of INJURY At hon atc. (Specify)	ne, farm, s	treet, factory, office			and Number o	or Rural Route Number,
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER D21936 296. LICENSE NUMBER D21936 Sept 29, 1995 Andrew 0. Done I son M.D. 915 To I house Ave Suite 203 Frederick MD 21701	LET									
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER D21936 296. LICENSE NUMBER D21936 Sept 29, 1995 Andrew 0. Done I son M.D. 915 To I house Ave Suite 203 Frederick MD 21701	COMP	(Check only one) 2 MEDICAL EXAMINER	: On the best of a	my knowledge, dea xamination and/or in	th occurre	d at the time, data n, in my opinion, d	and place, and due	to the cause(a) and mer time, data and place, an	ner as stated	d. cause(s) and menner as stated.
Andrew O. Donelson M.D. 915 Tollhouse Ave. Suite 203 Frederick MD 21701	BE	296. SIGNATURE AND TITLE OF CERTIFIER	. In	elson	M	0				
31. DATE FILED (Month, Day, Year) 32. REGINTRARYS SIGNATURE	۲	30. NAME AND ADDRESS OF PERSON WHO Andrew O. Donelso	n M D	915 Tol	Thou	SO ATTO				
COT O a coord die fice		31. DATE FILED (Month, Day, Year)	32. REGISTRA	H'S SIGNATURE	-			, ~ 20002.		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

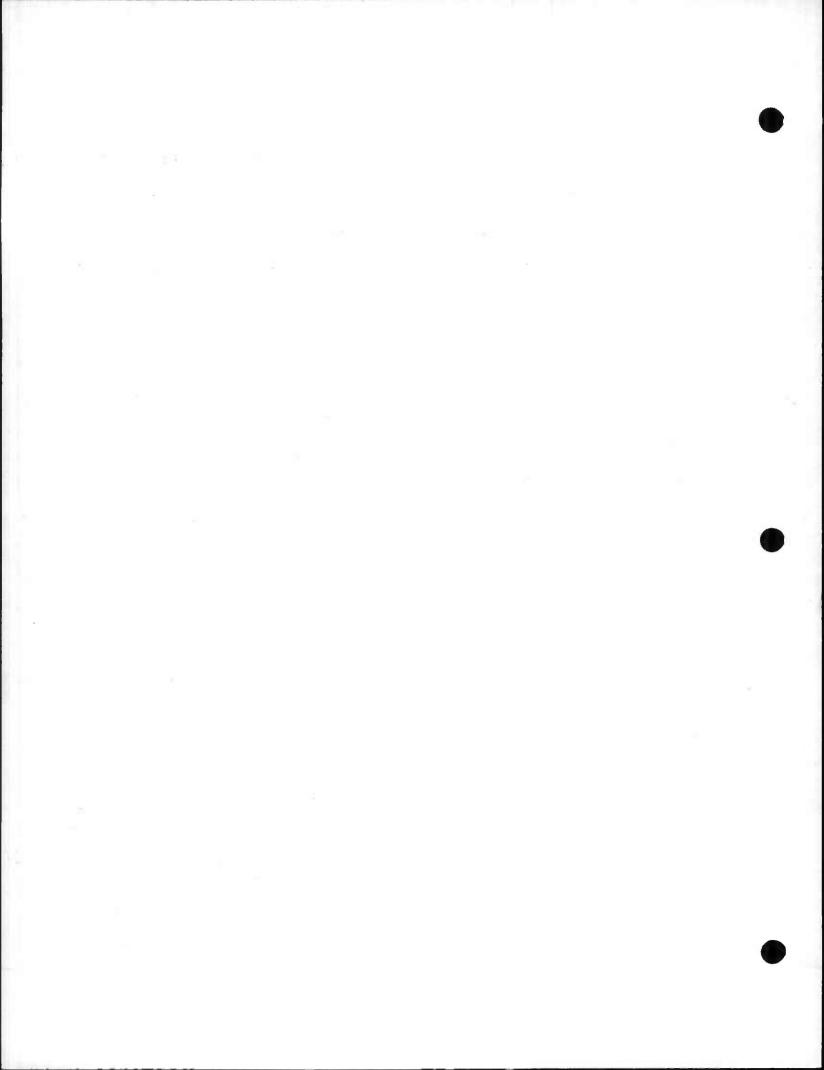
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, chemation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

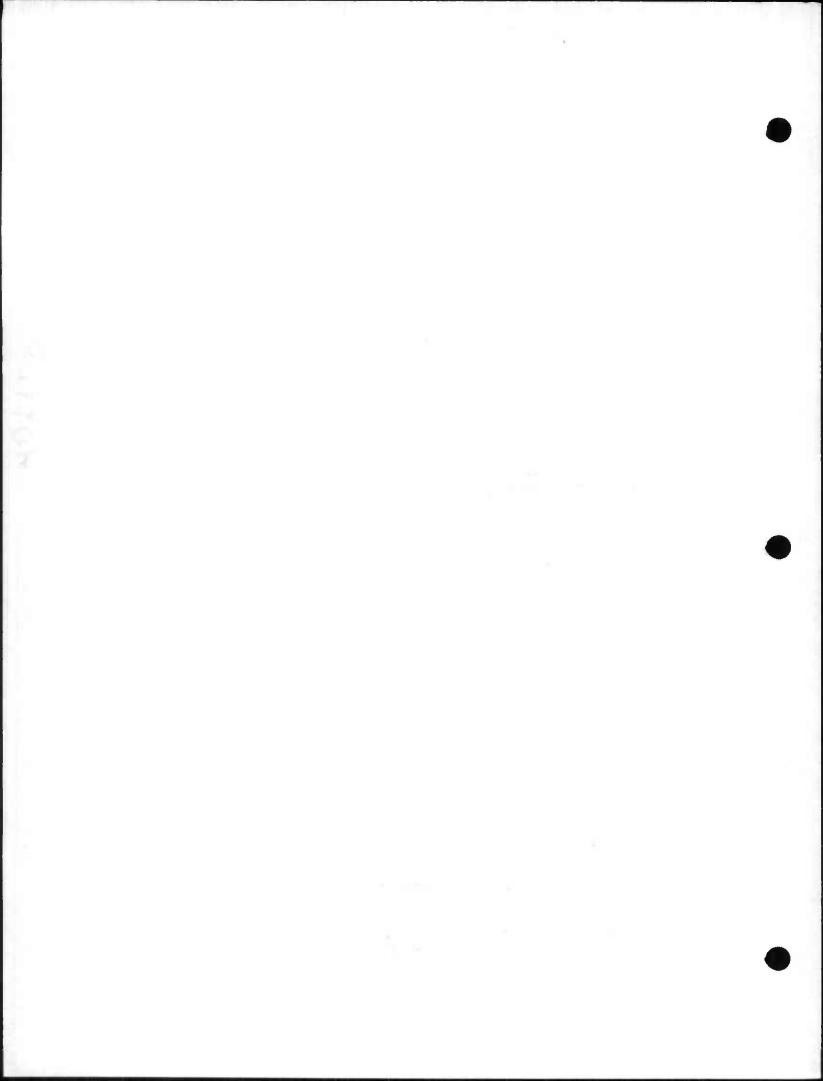
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
R98-	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR98-	STATE OF MARY	LAND / DEPARTM CERTIFIC	NENT OF HEALTH		NTAL HYGIEN	E	01270
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH
	JOHN	DAVID	MAHARES			CPTEMBER	27. 190	
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER	R 24 HRS. 7, 1	DATE OF BIRTH (Month, Day, Year)	6. BIF	THPLACE (State or Foreign
	212-98-3528	1 M 2 🗆 F	15 YRS.	NTHS DAYS HOURS	minut.	g. 16, 1		ryland
 ~	9a. FACILITY NAME (If not institution, give		1	CITY, TOWN OR LOCATE	ION OF DEATH		9c. COUNTY OF	
0	Frederick Mem	orial Hospit	al	Frederic	k,		Fred	erick
Di C	10e. STATE 10b. COUNT	ry	10c. CITY, T	OWN OR LOCATION				10d, INSIDE CITY
DIRECTOR	Maryland F	rederick	T÷	amsville				LIMITS?
	10e. STREET AND NUMBER	2002201	1 -1	10f. ZIP COD	E		10e. CITIZEN O	WHAT COUNTRY?
FUNERAL	3135 Pheasan	t Run			2175	/.		d States
S	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECENDENT (OF HISPANIC O	RIGIN? (Specify Yes	or No - 14. R/	CE American Indian.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	DATES NO	If yes, specify Cube		erto Rican, etc.)		eck, White, etc.
								White
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION is completed)	18a. DECEDENT'S USI	JAL OCCUPATION done during most of working tired.)	ng	16b. KIND OF BUS	INESS/INDUSTRY	
J.	Elementary/Secondary (0-12)	College (1-4 or 5+)		tired.)				
W	17. FATHER'S NAME (First, Middle, Lest)	_	Student		MEDIO MANER (High S		
		MES M	IAHARES					
BE	19e. INFORMANT'S NAME (Type/Print)	ried P		DRESS (Street and Number		LOUISE	COX	
2	JOHN J. MAHARES			heasant Ru				175/
	20s. METHOD OF DISPOSITION	20	0b. PLACE AND DATE OF D		1 / 1 /		CATION — City or	
	1 Buriel 2 Cremation 3 Rem		Resthaven		ardone			
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	1.COCHUVCII	22. NAME AND ADDRE	SS OF FACILIT	YStauffor	Euroze	Maryland
	Non mon 1	07		ı				
	23. PART I. Enter the diseases, or	complications that cause	ed the death. Do not	anter the mode of du	SSUMEO	vn Pike/I	rederio	ck,Md.21702
	shock, or heart fellure.	Liet only one ceuse on	each line.	anter the mode of dy	mg, auch as	cerdiec or respir	atory strest,	Approximate Interval Between
	IMMEDIATÉ CAUSE (Final disease or condition	C1000	25 10 11 -					Onset and Death
	resulting in death)	e. CARDIA	A CONSEQUENCE OF:					Immediate
z	_							Immediate
은	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):					Timilediace
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	· BRAIN	TUMOR					Unknown
플	that initiated events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE OF):					
H	Tesditing in deetin Exst	d						
AL O	PART II. Other significent condition	ne contributing to deeth	but not reculting in the	ne underlying ceuse (given in Part	I. 24a. WAS AN /	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
						PERFORI		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 TYES 2	_ NO	OF DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH YES	Пиопиис	ERTAIN [7		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C			-		
Sic	1 VES 2 NO	HOSPITAL: 1 Nopetient 2 □ ER/Ov		HER: Nursing Home 5 - Re	sidence 8 🗆	Other (Specify)		
1	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)				. DESCRIBE HOW IN	JURY OCCURED	
BY	1 Netural 5 Pending 2 Accident Invastigation	(mann, any, rous)	III ON	M 1 YES 2	ND			
	3 Suicide 8 Could not be	28e. PLACE OF INJUR building, etc. (Spi	IY — At home, ferm, stree ecity)	t, factory, office	281.	LOCATION (Street of City or Town, State)	nd Number or Rura	I Route Number,
	4 Homicide determined							
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	wledge, deeth occurred at	the time, data and place,	, end due to th	e cause(e) and meni	ner as stated,	
O.	one) 2 MEDICAL EXAMIN	ER: On the basis of examinati	on end/or investigation, in	my opinion, death occur	red at the time,	date end place, and	due to the cause	e(e) and menner se stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	37	1	29c. LICE	ENSE NUMBER		29d. DATE SIGNI	ED (Month, Day, Year)
		lavi fo	lan		44213		► 9/2	8/75
임	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Print					
		lamanchili ,	400 Wes	t 7th St.	/ Fred	erick, M	d. 21	701
	31. DATE FILED (MODIT) 0 2 1995	32. pegistrap's sig	NATURE			,		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ZA hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us having 72 hours after death with the State Dent, of Health and Mental Hotiere prior to burfal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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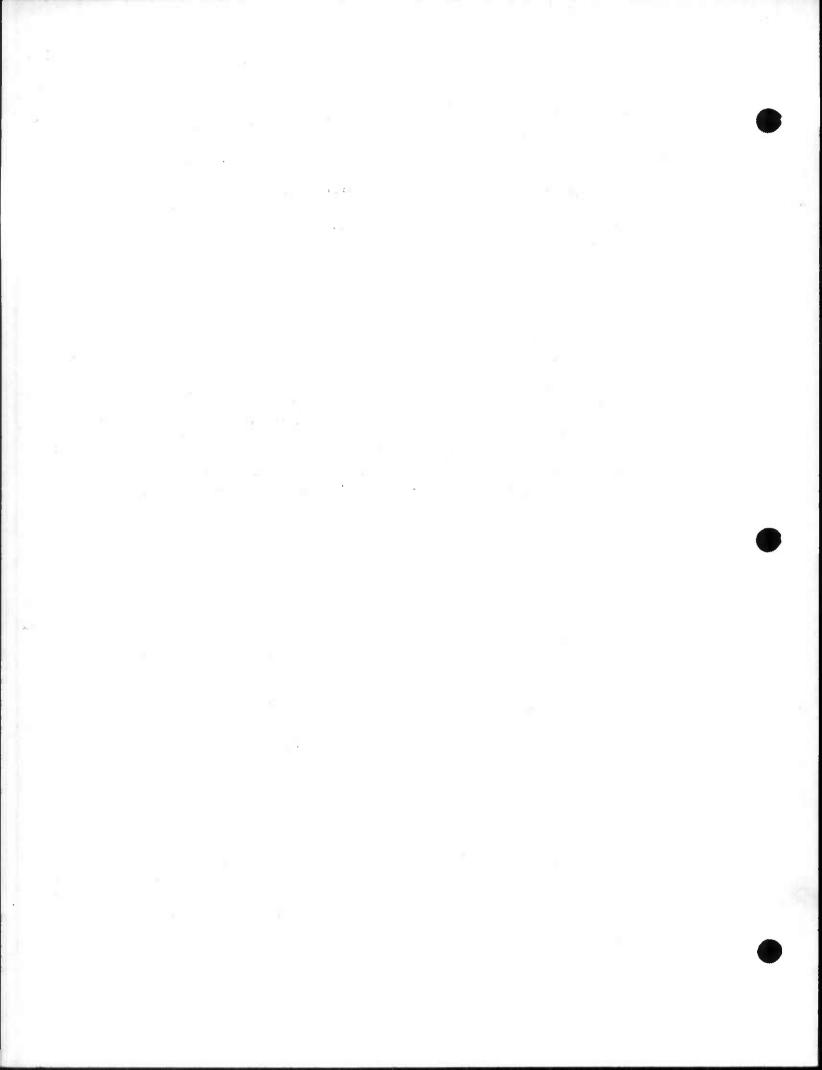
	FOR STATE REGISTRAR	TATE OF MARYLA	AND / DEPAR					MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lost) Nahketah Evan	geline NA	BORS					2. DATE OF DEATH MONTH September 2		YEAR	5:15 PM M
	4. SOCIAL SECURITY NUMBER 5. SI	EX 6. AGE (I	n yrs. last birthday)	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH		s. BIRTHPI	LACE (State or Foreign
OR	90. FACILITY NAME (If not Institution, give street or Homewood Retiremen			9ь. СІТУ, F		RLOCATIO		ATN	ec coun Free	deri	
DIRECTOR	Maryland Frederi	ck		deri		ON					IDD. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 31 West Patrick S	treet	1.		101.	ZIP CODE	701		10g. CITIZ	S.A.	NAT COUNTRY?
B		MAS DECEDENT EVER IN FORCES? 1 YES F YES, GIVE WAR OR DA		11	yes, spe			IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	s or No-	Black,	- American Indian, White, etc. Black
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade compile to th		16e, DECEDENT'S (Give kind of w life. Do NOT use	rork done de	uring mo:	N at of workin	g	18b. KIND OF BU	siness/inou	JSTRY	
BE COM	17. FATNER'S NAME (First, Middle, Lest) Robert		MAYRANI			18. MOTI	Cla	ME (First, Middle, Meider		WILL:	IAMS
TO B	198. INFORMANT'S NAME (Type/Print) Mrs. Jane N. Philli	ps	196. MAILING 4000 T	ADDRESS unla	(Street e	oad,	or Rural I	Route Number, City or Tov ., Apt. 91	on, State, Zip 6, Wa	shin	20007 gton,D.C.
	20. METHOD OF DISPOSITION 1. Burial 2 Cremellon 3 Removal for 4 Donation 5 Other (Specify)	B	PLACE AND DATE OF OF PARTY NAT	ional.	Ceme	tery,		10, 1995 I		, New	w Jersey
	21. SIGNATURE OF FUHERAL SERVICE LICENSE	9 1	M00255					asford P.A ch St., Fr			
	23. PART I. Enter the diseases, or compishock, or heert felture. List of IMMEDIATE CAUSE (Final disease or condition resulting in desth)	Pneumoni	ech line.		the mo	de of dy	ng, suc	h as cardiac or reep	erre	eel,	Approximata interval Between Onset and Daath 1 Week
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		CONSEQUENCE OF								
PHYSICIAN: MEDICAL	PART II. Other significant conditions con Dementia							PERFO	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ICIAN:		SPITAL:	28. PLACE OF DEAT	TH (Check o	only one)						
BY PHYS	1 YES 2X NO 1 1 27. MANNER OF DEATN 1. Natural 5 Pending 2 Accident Investigation	Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		28c. INJ WO			5 ☐ Other (Specify) 28d. DESCRIBE NOW	INJURY OCC	URED	
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	street, fecto	ory, offic			28f. LOCATION (Street City or Town, State		or Rural Ro	oute Number,
COMPLETED	29. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN:										and manner ee stated.
TO BE (29s. SIGNATURE AND TULE OF CENTER				-		164				Month, Dey. Year) , 1995
	Dr. Casper E. Clin	e MD 300 I	Jest Nint	h St	ree	t, F	cede:	rick, Mary	land	2170	1
	31. DATE FILE (MODIL) DIV. YOU 1995	32. RPGISTRAR'S SIGN	or Reves	•							



	Page	
	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page with the State Date of Health and Mental Husian prior to burial permit or manufall.	
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MYSICIAN: The law requires that the death certificate be executed within 18 hours after death. Page 6 may be retained by the hospital or attending physician.	State	CIRIC
NSICI	is cert	101
Y.	E 3	3

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	A DECEMENTIO MANUE (EL . ACLUE L					OF DEATH					
*	1. DECEDENT'S NAME (First, Middle, Last IRVIN	LEONA	RD		OI	WENS	MONT			YEAR	TIME OF DEATH
ŀ	4. SOCIAL SECURITY NUMBER		AGE (In yrs. Is	ant highdan	IF UNDER 1 YE			EMBER OF BIRTH			22:12
	218-16-1681	1 ☑ M 2 □ F		YRS.		AYS HOURS MIN.	. (Mont	h, Day, Year)		Country)	ACE (State or Fore
	9a. FACILITY NAME (If not institution, give	street and number)			9h CITY TO	WN OR LOCATION OF		cy 24		Mary TY OF DEAT	
۳							DEATH				in .
DIRECTOR	139 2nd STRE	<u> </u>			Nor	th East		-	CE	CIL	
ž I	10a. STATE 10b. COUN	ITY		10c. CIT	Y, TOWN OR L	OCATION				10	d. INSIDE CITY
	Maryland (Cecil			Nor	th East				1	YES 2 N
A	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITIZ	EN OF WHA	T COUNTRY?
FUNERAL	139 Second Stree	et				21901			Uni	ted S	tates
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. A	RMED	13. WAS	DECENDENT OF HISI	PANIC ORIGI	17 (Specify Yes	or No-	14. RACE —	American Indian
	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 FYES, GIVE WAR		,		YES 2 NO Spe		riicen, etc.)			White
	15. DECEDENT'S ED	US Army									
#	(Specify only highest grad	de completed)	(Give kind of the Do NOT us	Work done during	IPATION ng most of working	166	. KIND OF BUS	SINES\$/INDU	JSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	1		,			ew Hom			
COMPLET	17. FATHER'S NAME (First, Middle, Last)		r	TOOL	Sande			loorin		talla	tion
- 1	William A. Owens					18. MOTHER'S		0.011.			
出	19a. INFORMANT'S NAME (Type/Print)	· · · · · · · · · · · · · · · · · · ·	-	95 MAII ING	ADDRESS /S	reet and Number or Rur		rersme:		Codel	
일	Lucille C. Steir	nacker	1"								
	20s. METHOD OF DISPOSITION		20h BI ACE		OUE NIMO	ont Road,	Balti			21228	- Charles
	1 Donation 5 Other (Specify)	moval from State	cemetery, cr	rematory or o	ther plecel	cematory	1				
- 10-	21. SIGNATURE OF FUNERAL SERVICE L	LICENSEE	I R. A	rer			FACILITY	o west	_ unes	ter,	Penna.
1	NA OF	1/2	0			uch Funer					
	23. PART I. Enter the diseases, or	vou				South Ma:					MD 219
	IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	a. Aher	OS CLO			irdiova	scul.	ur	dise	rose	
RTIFICATION	disease or condition	b. DUE TO (OF		EQUENCE OF	F):	irdiova	sch(ur .	dise	eose	Interval Bet Onset and t
삥	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF DUE TO (OF d.	R AS A CONSE	EQUENCE OF	F): F):			ar .	dise	eose	
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MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the cause of the conditions are sufficient to the cause of the caus	DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF	R AS A CONSE	EQUENCE OF	F): F): In the under	rlying ceuse given	in Part 1.	24a. WAS AN. PERFOR	AUTOPSY MED?	24b. WE AM CO OF	Onset and Onset
MEDICAL CE	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions and the conditions of the conditio	DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF	R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE	EQUENCE OF DEATH	F): F): In the under In (Check only OTHER:	rlying ceuse given	In Part 1.	24a. WAS AN PERFOR	AUTOPSY MED?	24b. WE AM CO OF	Onset and I
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF	R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE	EQUENCE OF DEAT	F): F): In the under S	rlying ceuse given D UNCERTA one) Home 5 TResidence	In Part 1.	24a. WAS AN PERFOR 1 STYCE 2 Parm	AUTOPSY MEO? O NO	24b. WE AW	Onset and to
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ED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions and the conditions of the conditio	DUE TO (OF DUE TO	R AS A CONSE R AS	EQUENCE OF DEATH YEAR OF DEATH YEAR OF DEATH INJ.	F): F): In the under IN (Check only OTHER: 4 Nursing E OF UNY M 1 street, factory,	O UNCERTA One) Home 5 Residence D. INJURY AT WORK? YES 2 NO office	In Part 1. AIN 28d. Des	24a. WAS AN PERFOR 1 STYES 2 PATH TO (Specify) CRIBE HOW IN ATION (Street a or Town, State)	AUTOPSY MED? NO CAL NJURY OCCU	24b. WE AMO CO OF 1	Onset and I
EU BY PHYSICIAN: MEDICAL CE	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHY	DUE TO (OF DUE TO	R AS A CONSE R	EQUENCE OF DEATH ATTH YE LOCE OF DEATH ATTH YE LOCE OF DEATH ATTH ATTH ATTH ATTH ATTH ATTH ATTH	F): F): F): In the under In the under In (Check only) OTHER: 4 Nursing E OF 28c URY M 1 street, factory,	UNCERTA One) UNCERTA One) Home 5 TResidence INJURY AT WORK? YES 2 NO office	In Part 1. AIN 26d. Des 28t. Loc City lue to the cau	24a. WAS AN PERFORM 1 XYES 2 PUTT F (Specify) GCRIBE HOW IN ATION (Street a or Town, State)	AUTOPSY MED? NO Call NJURY OCCU and Number of	24b. WE AWE CO OF 1 DEPARTMENT OF Flural Flourist d.	Onset and
COMPLETED BY PHYSICIAN: MEDICAL CE	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHY	DUE TO (OF DUE TO	R AS A CONSE R	EQUENCE OF DEATH ATTH YE LOCE OF DEATH ATTH YE LOCE OF DEATH ATTH ATTH ATTH ATTH ATTH ATTH ATTH	F): F): F): In the under In the under In (Check only) OTHER: 4 Nursing E OF 28c URY M 1 street, factory,	UNCERTA One) UNCERTA One) Home 5 TResidence INJURY AT WORK? YES 2 NO office	In Part 1. De 6 Othe 26d. Det 281. LOC City Lus to the cache time, data	24a. WAS AN PERFORM 1 XYES 2 PUTT F (Specify) GCRIBE HOW IN ATION (Street a or Town, State)	AUTOPSY MED? NO CA NJURY OCCI Ind Number of	24b. WE AMO CO OF 1 DEPARTMENT OF Flural Flourist d. cause(a) an	Onset and
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O BE COMPLETED BY PRINCIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the conditions of the conditio	DUE TO (OF DUE TO	R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE 26. PLA R/Outpatient JURY Year) NJURY — At h (Specify) knowledge, d knowledge, d knowledge, d knowledge, d	EQUENCE OF DEAT 1 Some and the second	F): F): In the under F): In the under If (Check only OTHER: 4 Nursing E OF URY M 28c URY M 1 street, factory, ad at the time, in, in my opinic	UNCERTA One) Home 5 Residence LINJURY AT WORK? YES 2 NO office deta and place, and don, death occurad at the	In Part 1. AIN 26d. Des 26d. Des 26d. Des tune to the cache time, data	24a. WAS AN PERFORM 1 STYES 2 PATH T (Specify) CRIBE HOW IN ATION (Street a or Town, State)	AUTOPSY MED? NO A NJURY OCCI and Number of	24b. WE AMO CO OF 1 DEPARTMENT OF Flural Route d. cause(a) an	Onset and to
O BE COMPLETED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions and the conditions of the conditio	DUE TO (OF DUE TO	R AS A CONSE R	EQUENCE OF CEATING TO THE PROPERTY INVESTIGATION OF THE PROPERTY I	F): F): F): In the under S	Inlying ceuse given UNCERTA one) Home 5 Residence INJURY AT WORK? YES 2 NO office deta and place, and don, death occurad at to 29c. LICENSE N O. C. M	In Part 1. AIN 28d. Det 28d. Det 28t. Loc City Lua to the cache time, data	24a. WAS AN PERFOR 1 TO YES 2 PART SCRIBE HOW IN STREET AND TO YES AND THE STREET	AUTOPSY MEO? NO CA NO	24b. WE AW CO OF 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Onset and the control of the control
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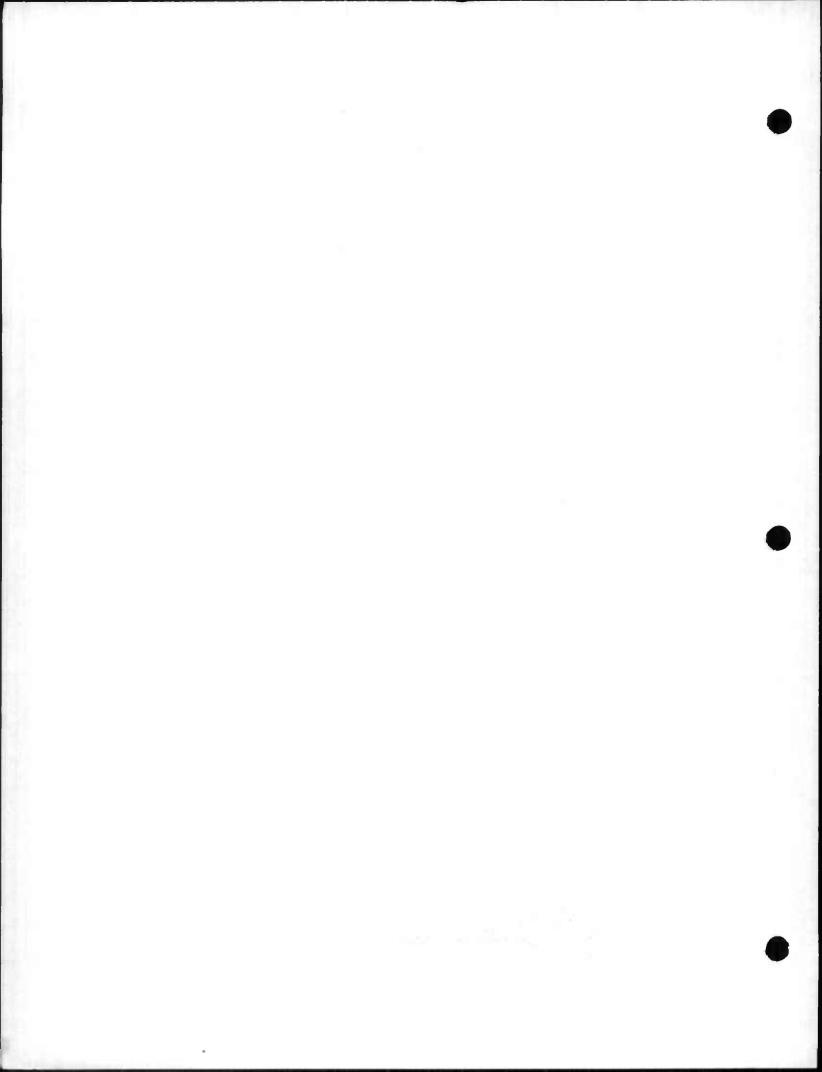
DIVISION OF VITAL RECORDS, P.O. BOX 6876

	FOR STATE REGISTRAR	STATE OF MARYLA		T OF HEALTH AND	MENTAL HYGIEN	E			
	t. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH		
	Alice F. Obrech	t.			Sept. 26				
				ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8, Bif	RTHPLACE (State or Foreign untry)		
	215-48-4362 t] YRS. MONTH	TY, TOWN OR LOCATION OF D	Nov. 14,		Maryland		
DIRECTOR	Severna Park Me	ridian Nu	rsing Ctr	. Severna	Park	Anne	e Arundel		
EG	10e. STATE t0b. COUNTY								
	Maryland Anne	Arundel	S	everna Par	k		t YES NO		
FUNERAL	10e. STREET AND NUMBER			tof. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
E	24 Truckhouse R	load		2114	6	τ	J.S.A.		
5		. WAS DECEDENT EVER IN FORCES? t YES		3. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico		or No- t4, R	ACE — American Indian, lack, White, etc.		
ВУ	t Never Married 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TES ZXNO Specif		Sį	pecify:		
	15. DECEDENT'S EDUCATI	ION T	tee. DECEDENT'S USUAL	00000471044	1		aucasian		
TE	(Specify only highest grade com	npieted)	(Give kind of work dor life. Do NOT use retired	e during most of working	16b. KIND OF BUS	SINESS/INDUSTR			
PLE	Elementary/Secondary (0-t2) C	College (1-4 or 5+)	Homen	akon		Ног	m o		
COMPLETED	t7. FATHER'S NAME (First, Middle, Last)		nomen		AME (First, Middle, Meiden		ii e		
	Aubrev E. Minor			Coldi	e Farson		77.17		
) BE	t9e. INFORMANT'S NAME (Type/Print)	CoorcoF S	19b. MAILING ADDRE	SS (Street end Number or Rural	Route Number, City or Tow	n, Statu, Zip Coglej	ev. Pk 2114		
5	Mr. Rick Obrech	t (Charle	s) 877 01	d Balt. An					
	20s. METHOD OF DISPOSITION X Burlet 2 Cremation 3 Removal		PLACE AND DATE OF DISP		DATE 20c. LO	CATION City or	Town, State		
	4 U Donetion 5 U Other (Specify)			k Cemetery		Baltime	ore, MD		
	21. SIGNAPORE OF FUNERAL SERVICE LICENS	SEE	2	Barranco &	Sons Fur	neral	Home 21146		
		Park, MD							
	PART Enter the disesses/ of com shock, or heart failure. List	plications that caused	the death. Do not ent	er the mode of dying, suc	ch as cardiac or reep	ratory arrest,	Approximate		
	IMMEDIATE CAUSE (Final	only one cause on ea					Interval Between Onset and Death		
- 1	disease or condition	CEN	EBROVI	15CULAN	1 Acer	DEN 7	12446		
	reaulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	tscular CAROTI		-			
Z	6.	BUA	TRA	CAROT 1	2 STE	FONE			
E	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						
3	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OD 40 A	CONSEQUENCE OF						
	that initiated events reaulting in deeth) LAST	DOE TO (OH AS A	CONSEQUENCE OF):						
CERTIFICATION	d								
AL	PART II. Other algnificant conditions c	ontributing to death be	at not resulting in the	underlying ceuze given in	Part I. 24e. WAS AN		24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
200					t 🗆 YES 2		COMPLETION OF CAUSE OF DEATH?		
ME					_		1 YE\$ 2 NO		
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	NO UNCERTAL	N CH				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL	26. PLACE OF DEATH (Che						
YSI	t YES 2 NO t	☐ Inpatient 2 ☐ ER/Outp		uraing Home 5 - Reeldence	6 Other (Specify)				
PH	27. MANNER OF DEATH t Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCURED			
BY	2 Accident Investigation		М	t YES 2 NO					
ED	3 Suicide 8 Could not be determined	building, atc. (Speci	— At home, ferm, street, f $f(y)$	actory, office	28t. LOCATION (Street City or Town, State)		ral Route Number,		
E	200 CERTIFIED	<u> </u>							
COMPLET	2			e time, date end place, end du y opinion, death occured at the					
8		THE SECOND OF GREATHERING	ondor investigation, in in						
8	29b. SIGNATURE AND TITLE OF CERTIFIER	AHEAA	d. C	29c. LICENSE NU	MBER C	29d. DATE SIGN	NED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	TH (ITEM 27) (None Print)	124	(/b	((810		
	DOGA MIN	DRA My	1600	RAIN 6	LENSU	RNIE	MD 2/06/		
	31. DATE FILED (Month, Day, Year) OCT 05 1995	32. REGISTRAR'S SIGNA							

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 pours after the may be retained by the hospital or attending physician.	ERAL DIRECTOR After this certificate has been signed by the attending physician and completely limited in by the human director, page 5 should be detached for use as the buriat-transit permit. Places 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal	MPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical azaminar must be notified at once.
THE HOSPITAL OR ATTER	TO THE FUNERAL DIRECTOR: After thi	filed within 72 hours after	PORTANT: If Item 28

	FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMENT	OF H	EALTH DE AT	AND I	MENTA	L HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
	Elmer 7	Theodore O	rme						Sept	ember i	28, 199	YEAR 25	8:10 A M
							IF UNDER		7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Country)			IPLACE (State or Foreign	
	216-07-3869	1 🖳 M 2 🗆 F	89	YRS.	MONTHS	DAYS	HOURS	MIN.		11, 1	906		yland
_	9e. FACILITY NAME (If not institution, give st	reet and number)					R LOCATIO	ON OF DE			9c. COU	NTY OF D	
DIRECTOR	11255 River Road				R	ldge	1y				9	Caro	line
E C	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			10c, CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
5	Maryland Card	oline		R	idgel	lv							LIMITS?
A	10e. STREET AND NUMBER				a dgo.		. ZIP CODI				10g. CITI	ZEN OF V	WHAT COUNTRY?
ER	11255 River Road						216	60				1	U.S.A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	R IN U.S. AR	MED						17 (Specify Y	s or No-	14. RACE	American Indian, t, White, etc.
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES				2 X NO			Rican, etc.)		Speci	
	15. DECEDENT'S EDUC	PATION							1				casian
	(Specify only highest grade	completed)	(Gi	ive kind of a Do NOT us	Work done o	turing mo	on st of workin	g	168	. KIND OF BI	JSINESS/IND	USTRY	
2	Elementary/Secondary (0-12) 11 HS Grad	College (1-4 or 5+)	100		t of	Ran	k				Banki	ncr	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1400	2001	0 01	Don	_	IER'S NA	ME (First	Middle, Meide		-9	
	Elmer The	eodore Orm	e						yra	Stev			
) BE	19a. INFORMANT'S NAME (Type/Print)		191	. MAJLING	ADDRESS	(Street e	nd Number	or Rural F	Poute Num	ber, City or To	wn, State, Zip	Code)	
2	Josephine D. Orme	9								, Mar			660
	20a, METHOD OF DISPOSITION 1 Carriet 2 Cremetton 3 Remo		Ob. PLACE			ITION (Na	me of		OAT	E 20c. L	OCATION -	City or To	wn, State
	1 Commetter 2 Cremetter 3 Removal from State Commetery, crematory or other place) 10/2 Denton, Maryland 21. SIGNAPORE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
. 1	21. SIGNAPORE OF PUNERAL SERVICE LICE	n n											100
	(Kandon	W. 110	one)						me, P		and.	21629
	23. PART I. Enter the diseases, or c shock, or heart failure. L	omplications that caus	ed the de	ath. Do r	not enter	the mo	de of dyi	ng, aucl	aa can	diac or res	olratory arr	eat,	Approximate
1	IMMEDIATE CAUSE (Final												Interval Between Onset and Death
	disease or condition resulting in death) a. ATHENOSCIENOTIC CANDIOVASCIAN DISEASE DUE TO (OR AS A CONSEQUENCE OF):									minutes			
	DUE TO (OR AS A CONSEQUENCE OF):												
S I	Sequentially list conditions,	DUE TO (OR AS		HENOR OF									
F	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS	A CUNSEC	DUENCE OF	r):								
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEC	UENCE O	F):								
CERTIFICATION	resulting in death) LAST												
¥	PART II. Other significant conditions	contributing to death	but not n	esuiting	in the un	derlying	cause g	jiven In	Part i.	24a. WAS A	NAUTOPSY RMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ğ										t 🗌 YES	2 1 NO		COMPLETION OF CAUSE OF DEATH?
ž													1 TES 2 THO
A N	of the oter persons to treate.												
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	DESCRIPT.		OTHER	:	ACE OF O						
₹	1 YES 2 WNO 27. MANNER OF DEATH	1 Inpetient 2 ER/O		28b. TIM	7	ing Hom 28c. INJ	5 M Re	sidence					
	1 Natural 5 Pending	(Month, Day, Year			URY	WO	RK?	1 40	28d. DES	CRIBE HOW	INJURY OCC	URED	
BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJU	RY — At hor	ne, ferm, s	street, facto			, NO	281 1.00	ATION (Street	and Number	or Rumi G	Inche Monthe
3 Suicide 6 Could not be determined 28t. LOCATION (Street and Number or Rural Roul City or Town, State) 28t. LOCATION (Street and Number or Rural Roul City or Town, State)							cute Namber,						
29c. CERTIFIER (Check only one) 29c. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.													
M	298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner ea stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner as stated.												
- 11	296. SIGNATURE AND TITLE OF CERTIFIER									ena piace, e		71000	
띪	7101	1 hors	0			- 1	ZWC. LICE	NSE NUM	BER //		29d, DATE	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	PEATH (ITEL	(27) (Type	Print)		V	219	66		1/	691	75
	Ludic T Fa	Bedin II	ms	61	26	7.7	-1		1-	1 6	7-10	1	2/60/
	31. DATE FILED (Mohin, Day (1987)	32 REGISTRAR'S SIG	SNATURE		0 1	101	MA	79~/	47	011		/d/ C	160/
	ULI = 4 95	Gruna Davids	on-Han	dell									



ARYLAND 21215-0020 ained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	PITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st
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		FOR 1 . STATE		STATE OF M	ARYLA	ND / DEPA	RTME	NT OF H	IEALTH AND	MENTAL HYGIEN	95 NE	Jl	280
		1. DECEDENT'S NAME (First	i, Middle, Last)	Pu	URD.		FICAT	TE OF	DEATH	2, DATE OF DEATH MONTH	DAY	YEAR	TIME OF DEATH P
		4. SOCIAL SECURITY NUMBER 220-24-5008				yrs. lest birthday) IF UNI	DER 1 YEAR B DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, See) JUNE 18 1		8. BIRTHPL	ACE (State or Foreign
3 should	H.	90. FACILITY NAME (If not in SOUTHERN MA			ī.		9b. CI	TY, TOWN C	TON	EATH		NTY OF DEAT	
jes 1, 2,	DIRECTO	RESIDENCE OF DEC				10c. C	ITY, TOW	OR LOCAT			PKI		EORGE
permit. Pages		MARYLAND 10e. STREET AND NUMBER		E ARUNDE	L	CRO	OWNS	VILLE				1	LIMITS?
25.	FUNERAL	959 WATERB	URY HEI						ZIP CODE			zen of wha JSA	AT COUNTRY?
ding physician. s the burial-transit	B	11. MARITAL STATUS 1 Never Merried 2 3 X Widowed 4 Divo	Merried	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES	2 NO	1	If yes, sp-	ENDENT OF HISPAI ecity Cuben, Mexico 2 X NO Specti	NIC ORIGIN? (Specify Year, Puerto Rican, etc.) y:	a or No—	14. RACE — Black, V Specify: BLAC	American Indian, White, etc.
tal or attending for use as the	LETED		DEDENT'S EDUCAT ly highest grade co. 0-12)			Ine. Do NOT	f work dor use retired	e during mo (.)	st of working	16b. KIND OF BU		USTRY	
the hospita detached once.	COMPL	12th 17. FATHER'S NAME (First, M	ficidle, Lest)	4yrs.		SUPERV:	ISOR	ATHL	ETIC DEP	T. BOWIE S		COLLE	IGE
d by th	BE C	JASPER TA	YLOR					per		WINKFIELD			
s retained to 5 should notified	70	JEANNETTE D								Floute Number, City or Tow.			
age 6 may be director, page or must be		20e. METNOD OF DISPOSIT NXBuriel 2 Cremetic 4 Donetion 5 Other	TION on 3 - Remova	al from State	cemete	PLACE AND DATE ery, crematory of BUTUS	E OF DISP	OSITION (Na	me of	DATE 20c. LC	OCATION —	City or Town	
e funeral		21. SIGNATURE OF FUNERA		SEE D. A	0	200	R.	2. NAME AN EESE	& SONS M		?A		
ed within 24 ompletely fill il, cremation event, the		23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	esit failure. Lis	C HF	e on eac	the death. Do	not ent	er the mo	da of dying, suc	th ss cardiac or reap	Iratory srn	est,	Approximata Interval Batween Onset and Daath OW North
be execucian and for to bur raumatic	RTIFICATION	Sequentially list condition of the sequential sequence of the	diate ING	DUE TO (C	OR AS A C	CONSEQUENCE	OF):						
attending rtal Hygies	CERTIFI	CAUSE (Disease or Inju thet initiated events resulting in death) LAS		DUE TO (O	DR AS A C	ONSEQUENCE	OF):						
requires that the of sen signed by the of Health and Me thows any injury	MEDICAL	Gohydlati	Renal	Incufy T	ficies	ney.	ion	, niet	astatic	PERFOI	RMED?	AV CC OF	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION DF CAUSE F DEATH? YES 2 NO
V: The law cate has be State Dept.	PHYSICIAN:	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL			DEATH 1	ATH (Chec		UNCERTAII	и 🗆 📗			
SICIAN: The lan certificate has the State Dep , or item 23	HYSI	1 TYES 2 NO		Inpatient 2 1		lent 3 🗆 DOA	_			8 Other (Specify)	hillm oo	1000	
DING PHYSI After this c death with s marked,	BY PI	1 Natural 5	Pending Investigation	(Month, Day,	y, Year)	1	M M	1 🗆 Y	RK? ZES 2 NO	28d. DEŞCRIBE NOW I	INJURY OCC	UNED	
L DR ATTENDING I DIRECTOR: After hours after death item 28 is man	ETED		Could not be determined	28e. PLACE OF building, at	INJURY — Ic. (Specify)	At home, term	, street, fi	ectory, office		281. LOCATION (Street City or Town, Stets)	end Number	or Rural Rout	e Number,
SPITAL DR A NERAL DIRE hin 72 hours NT: # item	COMPLI									to the cause(e) end ma-			nd manner se stated.
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If its	O BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER						D2 635		29d. DATE	SIGNED (M	onth, Day, War)

9/3/ PISCATAWA
32. REGISTRAR'S SIGNATURE

ROAD

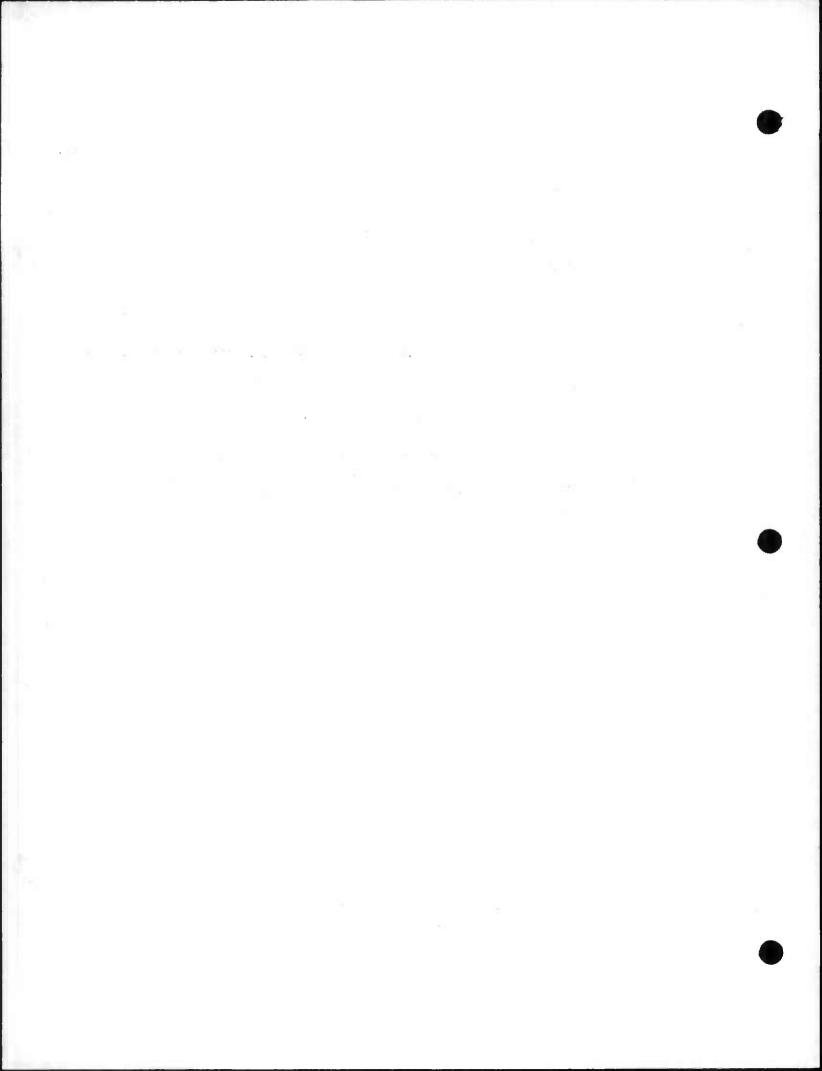
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31. DATE FILED (Morith, Day, Year)

OCT 03 1995

20735

Churon Maryland



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s hours after death. Page 6 may be retained by the hospital or attending physician.

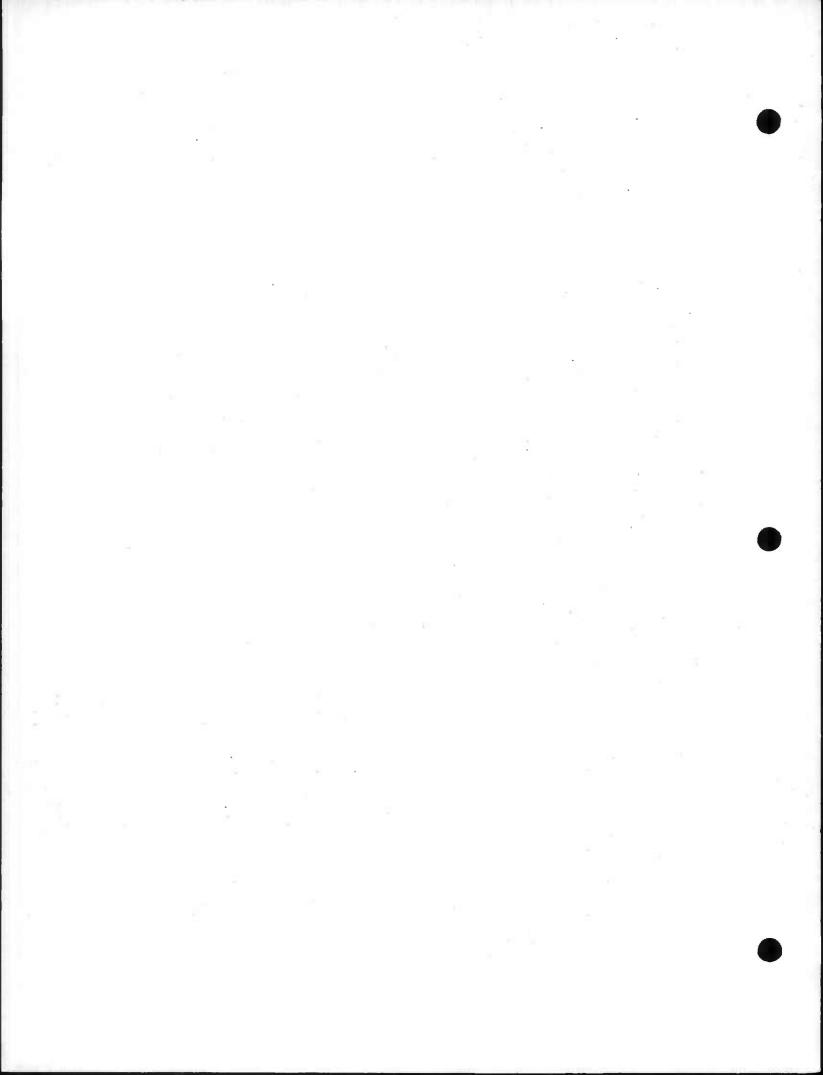
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF C	DEATH		WEAR	3. TIME OF DEATI	N
	RUTH	Lois	PALONE							SEPTEM	BER	17,1	1995	7:10	Рм
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. le	ast birthday)	IF UNDER		-	R 24 HRS.	7. DATE OF B (Month, Day	HRTN		8. BIRTH Count	PLACE (State or For	wign .
	220-10-8371		1 🗌 M 2 🙀 F	75	YRS.	MONTHS	DAYS	HOURS	MIN.	Februar		1920		Maryland	
_	9a. FACILITY NAME (If not in					9b. CITY, TOWN OR LOCATION OF DEATH						9c. COL	NTY OF E	EATN	
DIRECTOR	Berlin Nur	_	Home			В	erl	in				Wo	orces	ter	
ᇤᅵ	RESIDENCE OF DEC	10b. COUNT	y		10c CIT	Y, TOWN C	B LOCA	TION						44.4 110105 0174	
<u>E</u>	Maryland		icomico			rdel			or e					10d, INSIDE CITY LIMITS?	
	10e, STREET AND NUMBER		COMICO		110	iruer		. ZIP COD				40- 017	1751 05 1	1 YES 2 X	NO
FUNERAL	10321 Rive		24					2 18				10g. G1	USA	WHAT COUNTRY?	
뷬	11. MARITAL STATUS	I COII I	12. WAS DECEDEN	IT EVER IN U.S. A	RMEO	12.1	MAS DEC		•	IC ORIGIN? (S	andtu Van	or Ma		E — American India	
	1 Never Merried 2		FORCES? 1	YES 2 X	NO		t yes, sp	ecity Cubi	en, Mexica	n, Puerto Ricen		or No —	Blac	k, White, etc.	n,
B	3 Widowed 4 Divo	orced	11 123, 0172	WIT OH DATES			1 1 1 1 2 3	24 ANU	Specify	γ:			Spec	my: ∏hite	
COMPLETED		EDENT'S EDU		16a. D	ECEDENT'S Give kind of v	USUAL O	CUPATIO	ON		16b. KIN	D OF BUS	INESS/IN			
	Elementary/Secondary (0		College (1-4 or 5		e. Do NOT us	e retired.)		IST OF WORK	ng						
M M	12				Beaut	icia	n								
8	17. FATHER'S NAME (First, M	liddle, Lest)								ME (First, Middle					
BE	Sammuel		Will	iams					dna			Brumb	- 2		
5	19e. INFORMANT'S NAME (1			-11						Route Number, C					
- 1	Carole Tea			210	401	W. M	ain	SE.	, Fri	uitland	1, ML	218	326		
	20e. METHOD OF DISPOSIT 1 ☐ Burlel 2 ☐ Cremation	n 3 🗆 Rem	oval from State		AND DATE O					DATE			City or To	- I Activity	
ŀ	4 Donation 5 Other		CAUCEE /	Salis	bury					9/19	Sa	llish	oury,	, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home															
501 Snow Hill Rd., Salisbury, MD 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								MD 21801							
	25. PART I. Enter the d	iseeses, or o	complications the	t ceused the d	eeth. Do n	ot enter	the mo	de of dy	ing, suc	h se cardlec	or respir	ratory sr	rest,	Approxima	
	IMMEDIATE CAUSE (Fir		/)	-A- I		0		a 1		1		11		Interval Be Onset and	
disease or condition resulting in death) . Cletteriff cleratic Start Dy								ac	ere	150	us				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) s. Cuttures clurate Start Dependence of: Sequentially list conditions. b. Cuttures clurate Start Dependence of:														
z	Sequentielly list condit	lone T	0 00	ulra	liz	ed	U	re	un	osch	er	eac	0	5 4	no
Ĕ	If any, leading to imme- cause. Enter UNDERLY	diate	DUE TO	(OR AS A CONSE	QUENCE OF	7:									
CERTIFICATION	CAUSE (Disease or inju		cOUE TO	(OR AS A CONSE	OUENCE OF	n.								-	
	thet initiated events resulting in death) LAS	Т		(,									
8			d											+	
	PART II. Other significa	ent condition	s contributing to	Total Control		1 52			given in	Part I. 24a	. WAS AN		24b	WERE AUTOPSY FIN	
EDICAL	Jucon	u.	() 105 yr	uclu	e Pr			-	Luce	en 10	YES 2			COMPLETION OF CO	
¥	woods	mis	ral a	prtu	- Ce	nee	ung	for	/					1 - YES 2 X N	0
ż	Hyper		sion.	De	ne	es	ida								
딩	25. WAS CASE/REFERRED TO EXAMINER	O MEDICAL	HOSPITAL:			OTHE		ACE OF	DEATN (Ch	eck only one)					
ıs ∥	1 TYES 2 X NO		1 Inpstient 2	ER/Outpatient	3 🗆 DOA	OFHER 44 Num	ing Nor	• 5 □ R	esidence	6 Other (Sp	ecify)				
PHYSICIAN:	27. MANNER OF DEATH	Deadles	28e. DATE OF (Month, C	INJURY Day, Year)	26b. TIMI INJ	E OF URY	28c. INJ WC	URY AT		26d. DESCRIE	BE NOW IN	JURY OC	CURED		
à l		Pending Investigation				М	1 🗆		NO						
		Could not be	26e. PLACE C building,	of INJURY — At h otc. (Specify)	ome, term, s	street, fact	ory, offic	•		28t. LOCATION City or Tox	N (Street ei wn, Stete)	nd Numbe	r or Rural I	Route Number,	
로			CIAN: To the best of												
COMPLETED	one) 2 MED	ICAL EXAMINE	R: On the basis of a	xamination end/or	Investigatio	n, In my o	pinion, d	leath occu	red at the	time, data and	place, end	due to t	he cause(s	i) and menner es st	sted.
BEC	29h SIGNATURE AND TITLE	OF CERTIFIE	0.1	100			1	29c. LIC	ENSE NUM	ABER		29d. DAT	E BIGNED	(Month, Day, Year)	
0 D29505															
٩	30. NAME AND ADDRESS OF							-	****						
	DR. GREGOR					WOOD	PLA	CE,	CRIS	FIELD,	MD.	218	17 4	10-968-3	149
4	SEP 2 (1005	BZ REGISTRA	AR'S SIGNATURE	late										
1	OLI A	1000	a		4										J



DIVISION OF VITAL RECORDS, P.O. BOX 68760

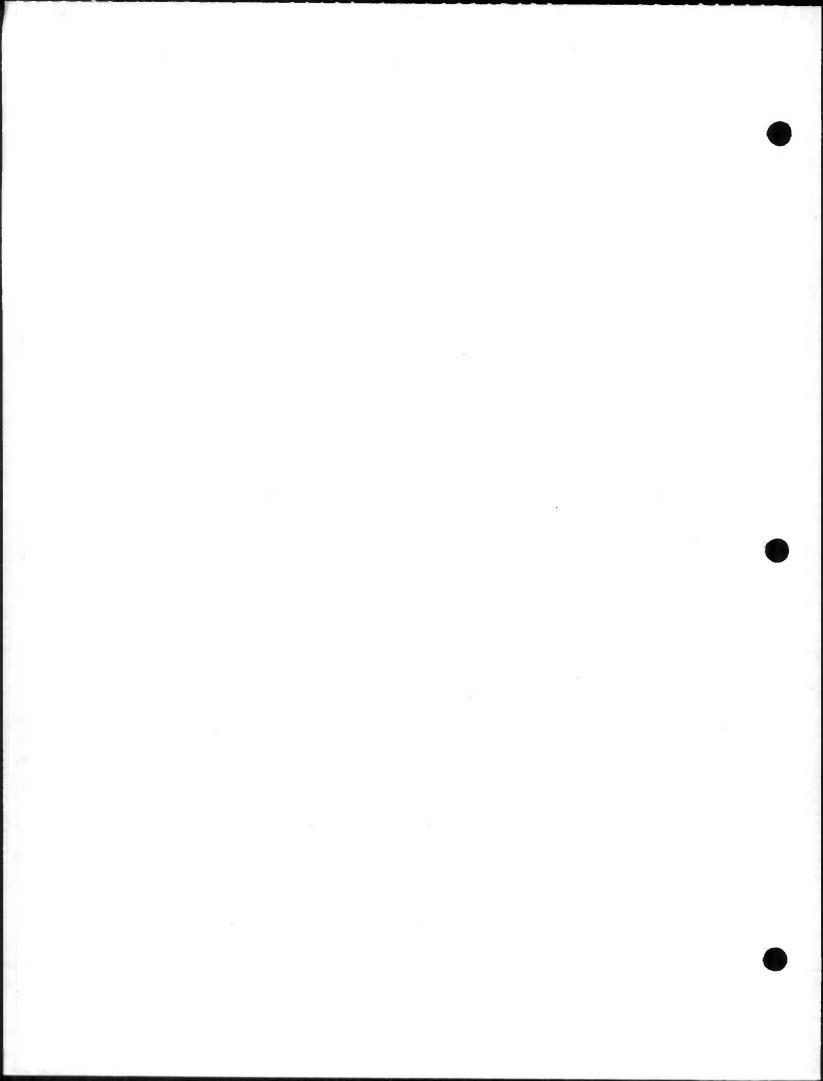
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IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND / D	EPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
		CEF	RTIFICATE	OF	- DEAT	H		REG. N	NO.

	1 - FOR STATE REGISTRAR	E OF MARYLAND		TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) ALBERT J	TACK PE	MBERI	ΓΟΝ		2. DATE OF DEATH Sept. 2	0 1 j	3. TIME OF DEATH 3:25		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreig	-	
	577-34-5218 1 X M 9e. FACILITY NAME (If not institution, give street end not		7 YRS.	9b. CITY, TOWN OF	HOURS MIN.			ashington, D of DEATH	.c.	
DIRECTOR	Memorial Hospital		Easton				Talbot			
JEC	10a, STATE 10b, COUNTY		10c. CITY	Y, TOWN OR LOCATI	ION			10d. INSIDE CITY		
	Maryland Caroline	<u>}</u>		Denton 10f.	ZIP CODE		10g. CITIZEN	1 XYES 2 NO	0	
ER/	627 Camp Road				21629		U.S.	.A.		
BY FUNERAL	1 Never Merried 2 Merried IF YE	DECEDENT EVER IN U.S. CES? 1 X YES 2 ES, QIVE WAR OR DATES		It yes, spe		IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify:		
	15. DECEDENT'S EDUCATION	rean 16a.	DECEDENT'S	USUAL OCCUPATION	N .	16b. KIND OF BU		aucasian		
COMPLETED	(Specify only highest grade completed)	(Give kind of willfe. Do NOT us	work done during mos	st of working					
AP.	9	, , , , , , , , , , , , , , , , , , , ,	auffer	ur/Butler		Priva	te Fam	ilv		
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden				
BE		Pemberton			The state of the s	Marie Cap				
6	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov				
	Mary S. Pemberton			amp Road,		, Maryland	21629 CATION — City		-	
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Removal from		crematory or of	ther place)						
4 Doneston 5 Other (Specify) Eastern Shore Crematorium 9/21 Georget 22. NAME AND ADDRESS OF FACILITY								1. Delaware		
	telealist lew	200				al Home, P Denton,		nd 21629		
	23. PART I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, present fellure. Liet only pne cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PART II. Other algoriticant conditions contril Hyperlipidemia,	Degener	ative	Joint	Disea	Je 1 PERFO	RMED?	24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO	USE	
ä	DID TOBACCO USE CONTRIBUTE				UNCERTAIL	NO				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ITAL:		TH (Check only one) OTHER:					-	
IYS		etient 2 ER/Outpetient	28b. TIM			6 Other (Specify) 28d. DESCRIBE HOW	IN ITIES OCCUR	ED.		
	1 Natural 5 Pending	(Month, Day, Year)		JURY WO	RK?	294. DESCRIBE NOW	INSONT OCCOR			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	b. PLACE OF INJURY — At building, stc. (Specify)	l home, term, s			261, LOCATION (Street City or Town, State		Rural Route Number,		
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner ee stated.									
8	2 MEDICAL EXAMINER: On the	basis of exemination end	/or investigatio	on, in my opinion, a					led.	
BE	29b. SIGNATURE AND THEE OF CERTIFIER	1			D332		29d. DATE SI	GNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEATH (ITEM 27) (Time	e, Print)	0370	7 7	7/	20/95		
	Robinson Lappin, M.I				fare function	21620				
	31. DATE EILED-(Month, Day, Year) 32.	REGISTRAR'S SIGNATURE	E	Denton, N	ar A Talla	21023				



09/89	executed within 24 hours after	and completely filled in by t	o burial, cremation, or remov	natic event, the medica
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	TO THE FUNERAL DIRECTUR: After this certificate has been signed by the attending physician and completely filled in by t	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remov	IMPORTANT. If Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medica

HECTOL C. A

31. DATE FILED (Month, Day, Year)
SEP 2 7 1995

		1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF		MENTAL HYGIEN	_	
		1. DECEDENT'S NAME (First, Middle, Last) Claudia	Ellen	Pool	е		2. DATE OF DEATH MONTH Sept 25	1995 '	EAR 3. TIME OF DEATH
ь		4. SOCIAL SECURITY NUMBER 215-62-6301	1 M 2 SF	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day Year)	906	BIRTHPLACE (State or Foreign County) Maryland
2, 3 should	OR	9a. FACILITY NAME (If not institution, give str 21001 Westerly				OR LOCATION OF DI	EATH	9c. COUNT	of DEATH GOMERY
← i	DIRECTOR	HESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD Monto	gomery		TOWN OR LOCA				10d. INSIDE CITY LIMITS?
burial-transit permit. Pages	ERAL	100. STREET AND NUMBER 21001 Westerly	Road		10	01. ZIP CODE 20837			1 ☐ YES 2 ☑ NO N OF WHAT COUNTRY? S.A.
the the	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 NO	If yes, s		NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:	8 or No — 14	RACE — American Indian, Black, White, etc.
detached for use as once.	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)		ork done during m retired.)	ON ost of working	16b. KIND OF BU		TRY
be detached at once.	COMPL	9 17. FATHER'S NAME (First, Middle, Last) David O. Johnso	on.	Homer	naker	18. MOTHER'S NA	ME (First, Middle, Meiden		
e 5 should notified	TO BE	190. INFORMANT'S NAME (Type/Print) Franklin Poole	711			and Number or Rural	Route Number, City or Tow		Md 20838
rector, page		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)		p. PLACE AND DATE OF netery, crematory or oth	DISPOSITION (N er place)		OATE 20c. LO	CATION — City	y or Town, State ville, MD
he funeral di ral. I examiner		21. SIGNATURE OF FUNERAL SERVICE LICE	Hutt		22. NAME A Hil			е	× 1 1 1 C 1 1 1 D
ompletely filled in by the cremation, or remove event, the medical		23. PART I. Enter the disease, or conshock, or heert fellure. LIMMEDIATE CAUSE (Finel disease or condition resulting in death)	amplications that cause on e ist only one cause on e	each line.	ot enter the mo	ode of dying, suc	h as cardlec or reapl	Iratory arrest	Interval Between Onset and Death
anding physician and coll Hygiene prior to buria	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST		A CONSEQUENCE OF)	:				
been signed by it. of Health and shows any li	AN: MEDICAL C	PART II. Other algorificant conditions 144 PRIVATE VAN HEART FAILUR DID TOBACCO USE CONTR	8999NNA	L			PERFOR	IMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
certificate has the State Dep 1, or Item 23	HYSICIA	1 YES 2 NO	HOSPITAL: 1 Diripatient 2 DER/Outp		OTHER:	ne 5 / Rasidence	8 Other (Specify)		
After this death with s marked	D BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	28b. TIME INJU	M 1 🗆	JURY AT DRK? YES 2 NO	28d. DESCRIBE HOW II		
AL DIRECTOR: 72 hours after 1f Item 28 I	MPLETE	4 Homicide detarmined 29a. CERTIFIER (Check only	AN: To the best of my know	ledge, death occurred					
within TANT:	8						time, date and place, an	d due to the c	GNED (Month, Day, Year)
TO THE be filed	0 8	poor Hor	men-	MD		D 00	995 mp		27/95

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ASUNCION MD 17600 W-Willowd

ASUNCION MD 17
32 AGGISTRAT'S SIGNATURE
JULY D'AUGUSTRAT'S SIGNATURE
JULY D'AUGUSTRATIS SIGNATURE

AS JULY D'AUGUSTRATIS SIGNATURE

AS JULY D'AUGUSTRATIS SIGNATURE

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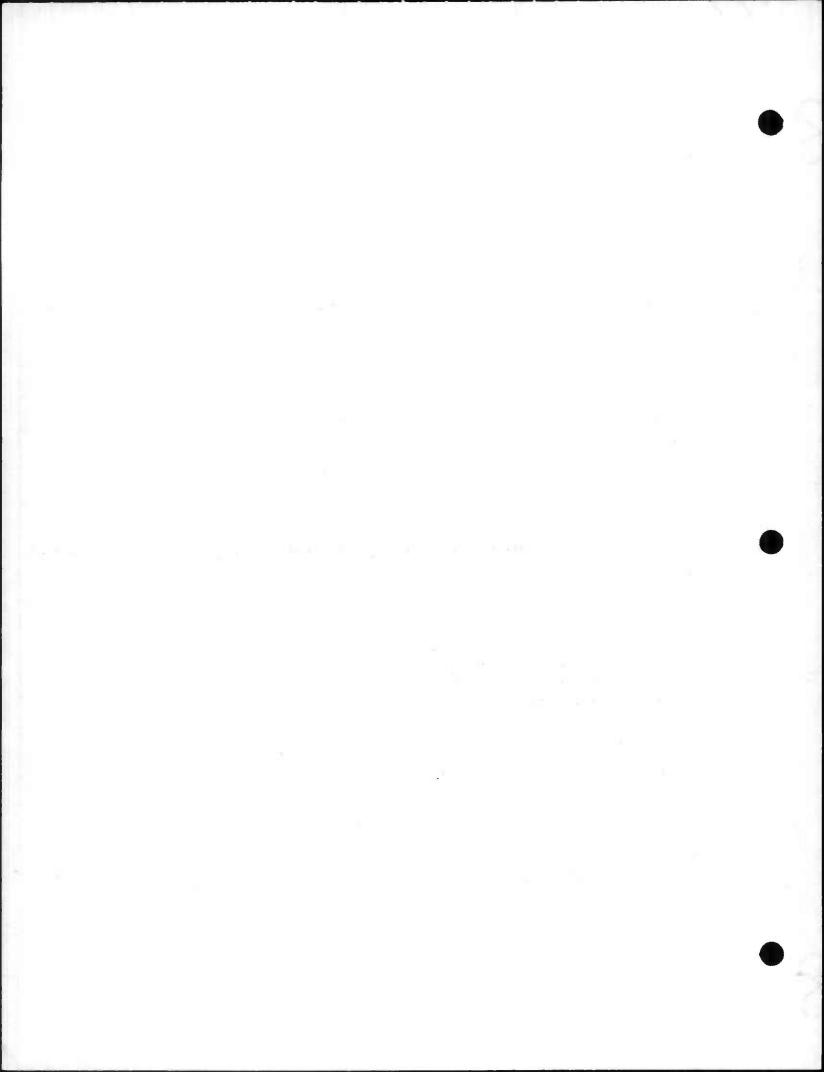
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2. DATE OF OEATH

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BALTIMORE. MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Charles Frederick Robinson, Sr. 5. SEX

DIVISION OF VITAL RECORDS P.O. BOX 68760

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	SSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the	NEBAL DIRECTOR: After this certificate has been stoned by the attending physician and completely filled to by the funderal diseason page 5 should be a
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31. DATE FILED (Month, OC

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2, 3 should		98. FACILITY NAME (If not in	nstitution, give s	treet and number)				9b. CITY, TOWN OR LOCATION OF DEATH							
		Dorchester General Hospital Cambr										oridge			
	DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	1			10c CIT	TOWN	N OR LOC	ATION					
Page	JE I	Maryland	Do	rchester			100. 011		brid						
tained by the hospital or attending physician. should be detached for use as the burial-transit permit. Pages 1, tiffled at once.		106. STREET AND NUMBER 101. ZIP CODE													
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by the		George Her		obinson.	Jr.					16. MOTHER'S NAME (First, Middle, Ma Magdalene J					
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5 5	2	Carolyn B.	Robin	son						ter Drive Cambrid					
6 may be ctor, page nust be		20a, METHOD OF DISPOSIT	ION	oval from State	201	PLACE.	AND DATE	OF DISP	OSITION	N (Name of			200		
th certificate be executed with fours after death. Page ending physician and completely filled in by the funeral dire if Hygiene prior to burial, cremation, or removal.		4 Donation 5 Other	D	orch	orchester Memorial Park 10/4										
		22. NAME AND ADDRESS OF FA Thomas Funera 700 Locust St										al Home,			
	\neg	23. PART VEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or													
		shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
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TAL OR ATTENDING PHYSICIAN: AL DIRECTOR: After this certifica 72 hours after death with the St if Item 28 is marked, or it	SIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) Then the state of the state									sidence	• · · · · · · · · · · · · · · · · · · ·			
	PHY	27. MANNER OF DEATH 1 Netural 5	Panding	26a. DATE OF (Month, Da	INJURY		28b. TIM		28c. IN				CRIBE HO		
	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — Al home, larm, street, lactory, office 28i. LOCATI										TION (Stor Town, S			
	COMPLETE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of as											
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h IMPORTANT: It I	O BE CO	29b. SIGNATURE AND TITLE			- CONTRACTO	end/of	rvanyanc	et, in my	y opinion,	,	NSE NUM		and place		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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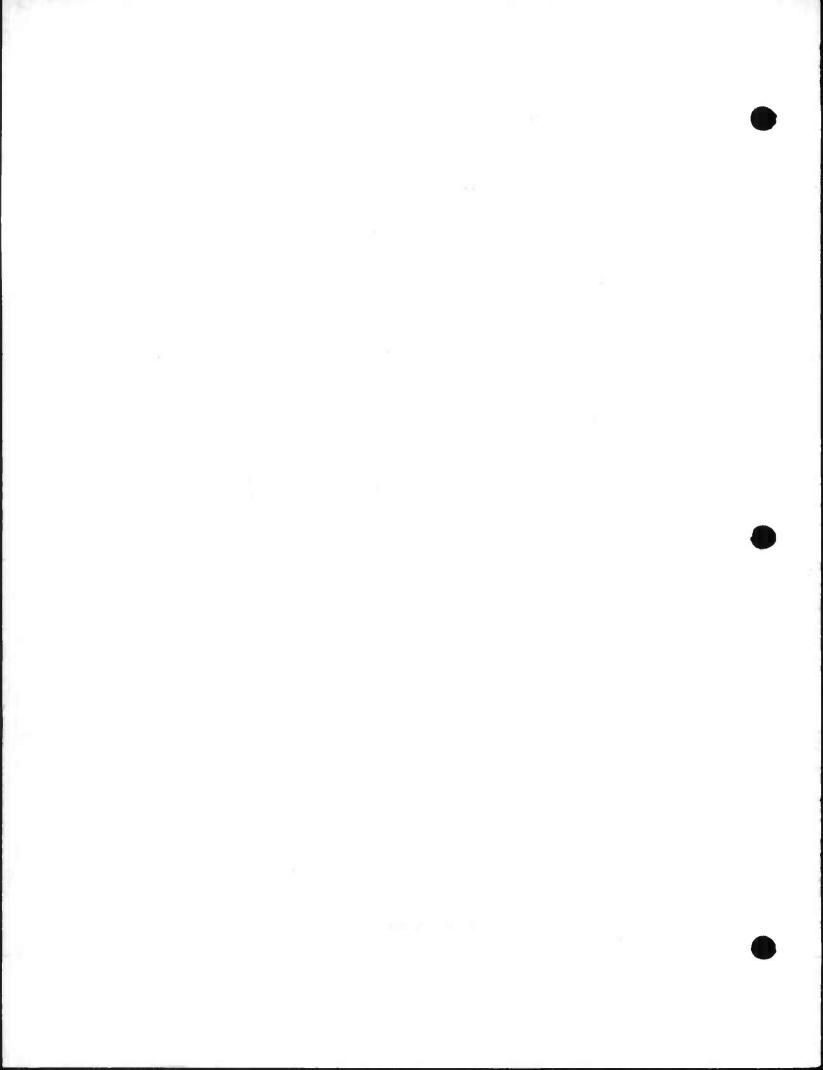
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF IMDER 24 4

3. TIME OF DEATH BIRTH Day, Year) 28, 1941 Maryland 9c. COUNTY OF DEATH Dorchester 10d. INSIDE CITY LIMITS? 1 YES XX NO 10g. CITIZEN OF WHAT COUNTRY? US Specify Yea or No-14. RACE — American Indian, Black, White, atc. Specify: White ND OF BUSINESS/INDUSTRY Warehousing dle, Maiden Surname) Johnson City or Town, State, Zip Code) ridge, Maryland 21613 20c. LOCATION - City or Town, State Cambridge, Maryland e, P.A. oridge, Maryland 21613 Approximata interval Between Onset and Reath 6 months 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? a. WAS AN AUTOPSY PERFORMED? TYES 2 NO 1 YES 2 NO IBE HOW INJURY OCCURED ON (Street and Number or Rural Route Number, lown, State) a) and manner as stated. d place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Gilbert SR. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH 217-28-6076 1 🔀 M 2 🗌 F 5-10-28 HOURS Maryland YRS. 67 Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll County General Hospital Westminster Carroll 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 1 X YES 2 NO Carroll Taneytown permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10s, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 10 Fairview Avenue, Apartment #3 21787 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Ves 2 No IF YES, GIVE WAR OR DATES COrean 1951-53 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES 2 XNO Specify: BY 3 Widowed 4 Divorced Specify: Korean Caucasian ED 15. DECEDENT'S EDUCATION secify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Sp E (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 6 Carpenter Construction once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 7 BE Earl Stanley Runkles, Sr. Nellie Mae Brightwell notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Betty I. Runkles 10 Fairvew Ave. Taneytown, MD 21787 Раде 6 тау be 9 20s. METHOD OF DISPOSITION

1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must competery, cremetory or other place)
Linganore Cemetery 10 - 5Unionville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY uted within 24 hours after death, completely filled in by the funerarial, cremation, or removal. 136 E. Baltimore St. Skiles Funeral Homes 00 Taneytown, MD 21787 medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. in and completely filled i IMMEDIATE CAUSE (Final **Onset and Death** the disesse or condition peard Minute event, resulting in death) executed with DUE TO FOR AS A CONSEQUENCE OF knovele traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician ntal Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST 0 the atter Injury. the PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Health and N (that shows any 1 TYES 2 THE OF DEATH? requires 1 - YES 2 - NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES MO UNCERTAIN has be OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL OTHER: 1 - Inpetient 2 - ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? marked, 1 Natural 5 Pending M 1 YES 2 NO After to death BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 40 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d item 28 is 8 Could not be 0 4 Homicide datermined Ш hours Hem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. COMPL FUNERAL C within 72 h (Check only one) HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND THE OF CERTIFIER 29d. DATE SIGNED (Mont), Day, Year) BE (0 1ai 10 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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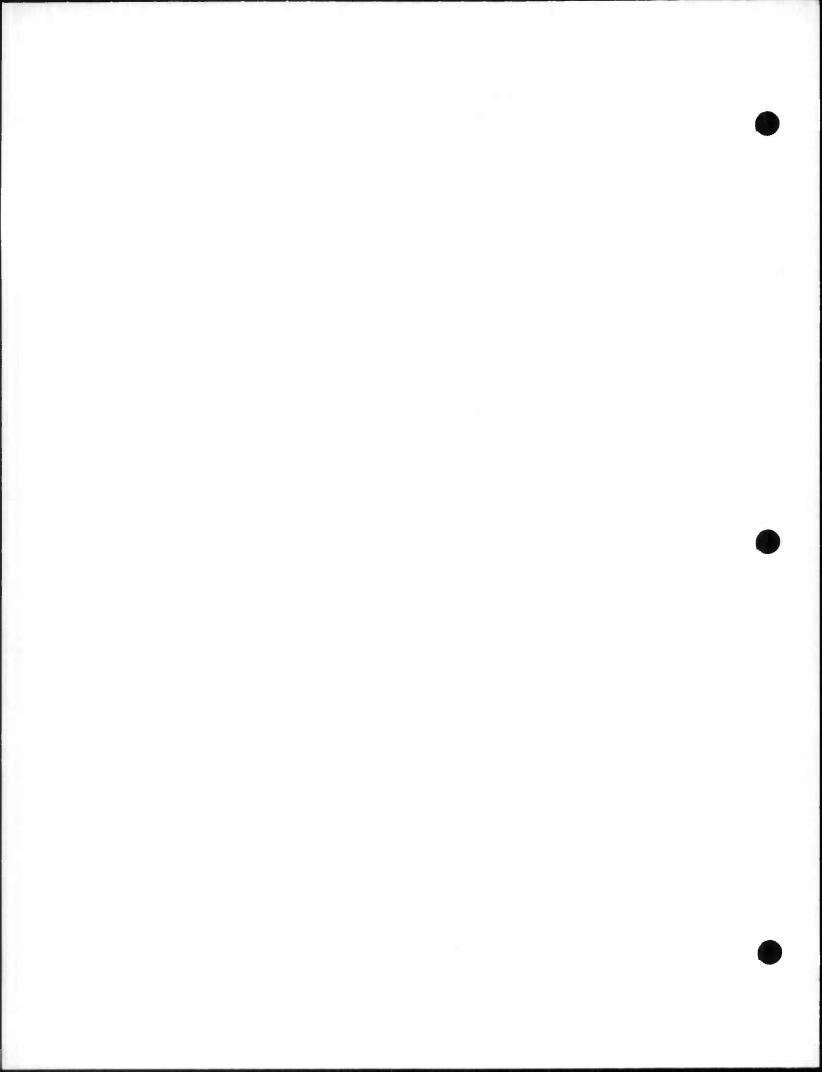
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BALTIMORE, I ber death. Page 6 may be u the funeral director, page 4 wal.		1 Buriel 2 Cremation 3 Removal from State														
Page al dire		4 Donation 5 Other (Specify) Meadowridge Cemetery 10-04-95 Dorsey, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													MD	
ALTIM death. Page theral direct.		Barranco and Sons Funeral Home														
a FE		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate														
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Charles Walter Keve 0820 cotenber 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 222-05-0283 1 X M 2 | F 78 HOURS MIN. YRS 11/22/1916 Delaware 9a. FACILITY NAME (If not institution, give street and number 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Pittsville Maryland Wicomico 1 YES 2 X NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21850 6965 Sixty Foot Road usa 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Narried Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 poultry farming pountry farmer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Downes John G. Revel B notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6965 Sixty Foot Rd., Pittsville, Md. 21850 9 Rhonda M. Wootten Revel 9 20g METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must 4 Donation 6 Other (Specify) 9/26 Millsboro Cemetery Millsboro, Delaware examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Michay Watson Funeral Home, Millsboro, Delaware alzer medical 23. PART i. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fellure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition asperatory arrest reaulting in death) MUS other traumatic event, DUE TO (OR AS A CO EQUENCE OF Chinic Conjutive Wears CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate Heart cause. Enter UNDERLYING home the attending physical Mental Hygiene p CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24e. WAS AN AUTOPSY PERFORMED? Astmali Brucht shows any 1 YES 2 ILNO OF DEATH? Mumm 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Item 23 s 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL:
1 1 mpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Name 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 | Netural 5 Pending 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 6 Could not be 4 Homicide 28 Hem 29e. CERTIFIER

1 GERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 THE TIMPORTANT: If IL 2 MEDICAL EXAMINER: On the basia of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Ybar) BE Musely M (MMM) 9/21/95 010688 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Donald Wood

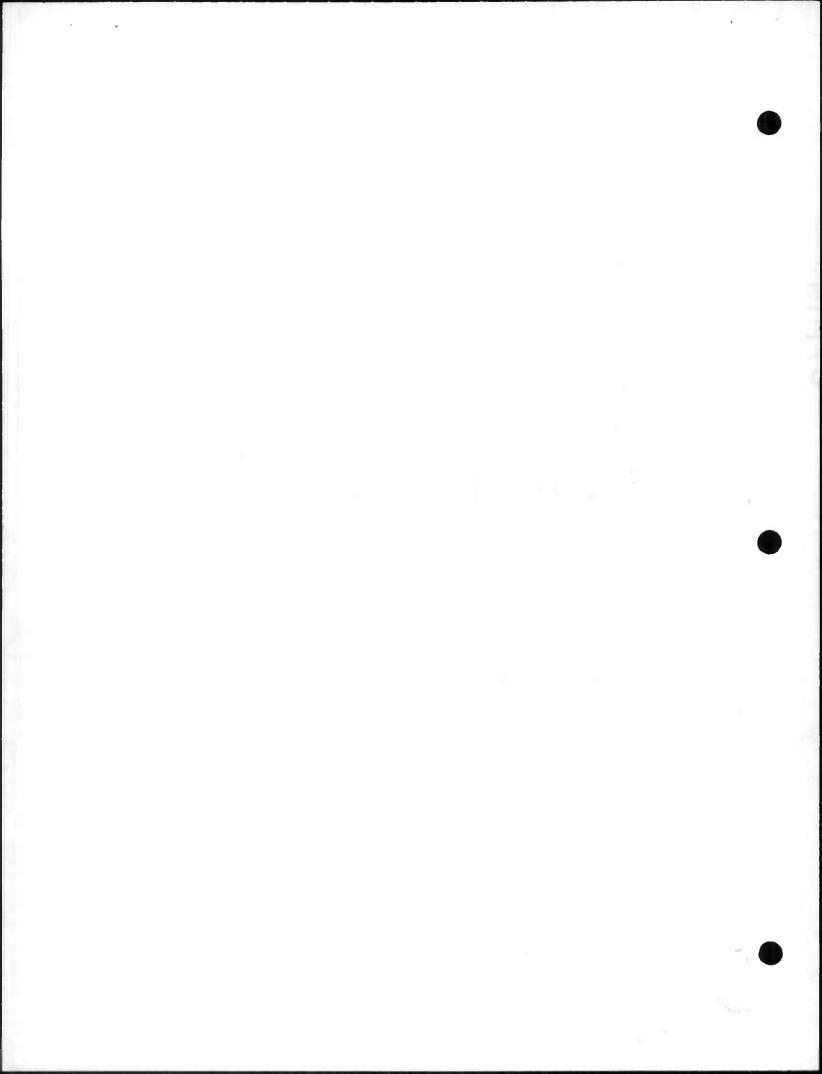
31. DATE FILEO (Month, Day, Year) SEP 25 1995

Quincy

32 MEGISTRAR'S GIGNATURS

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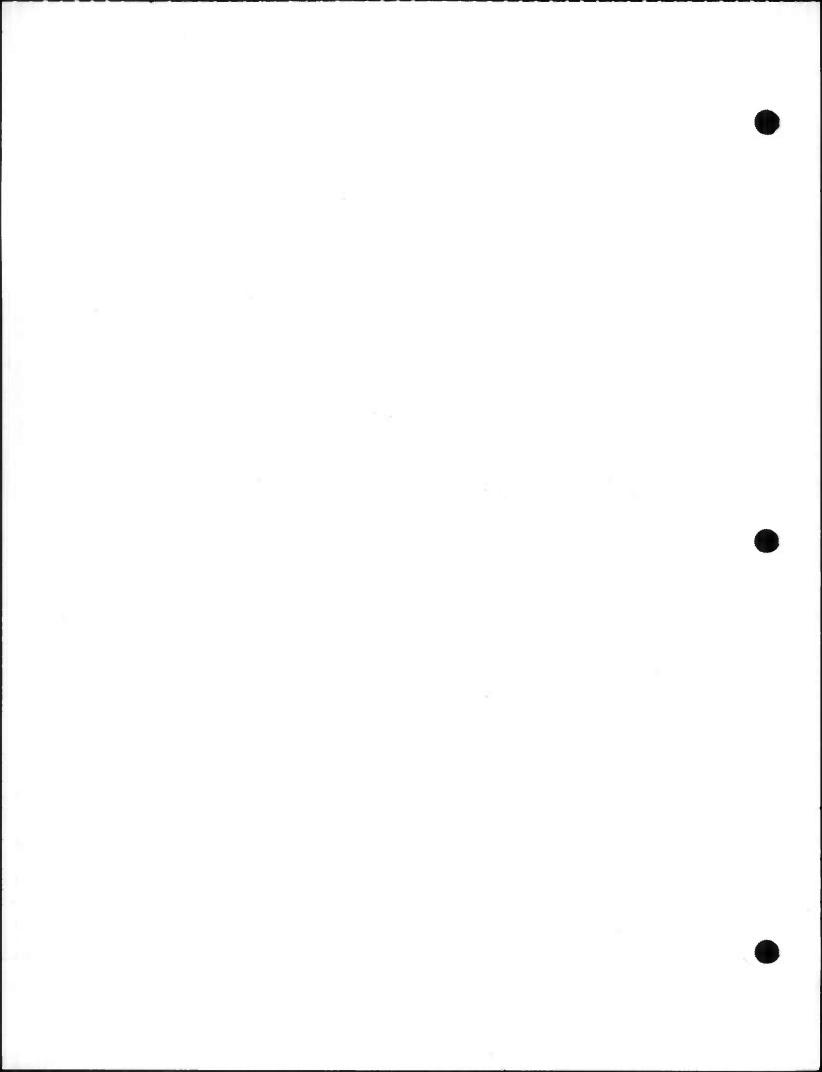
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

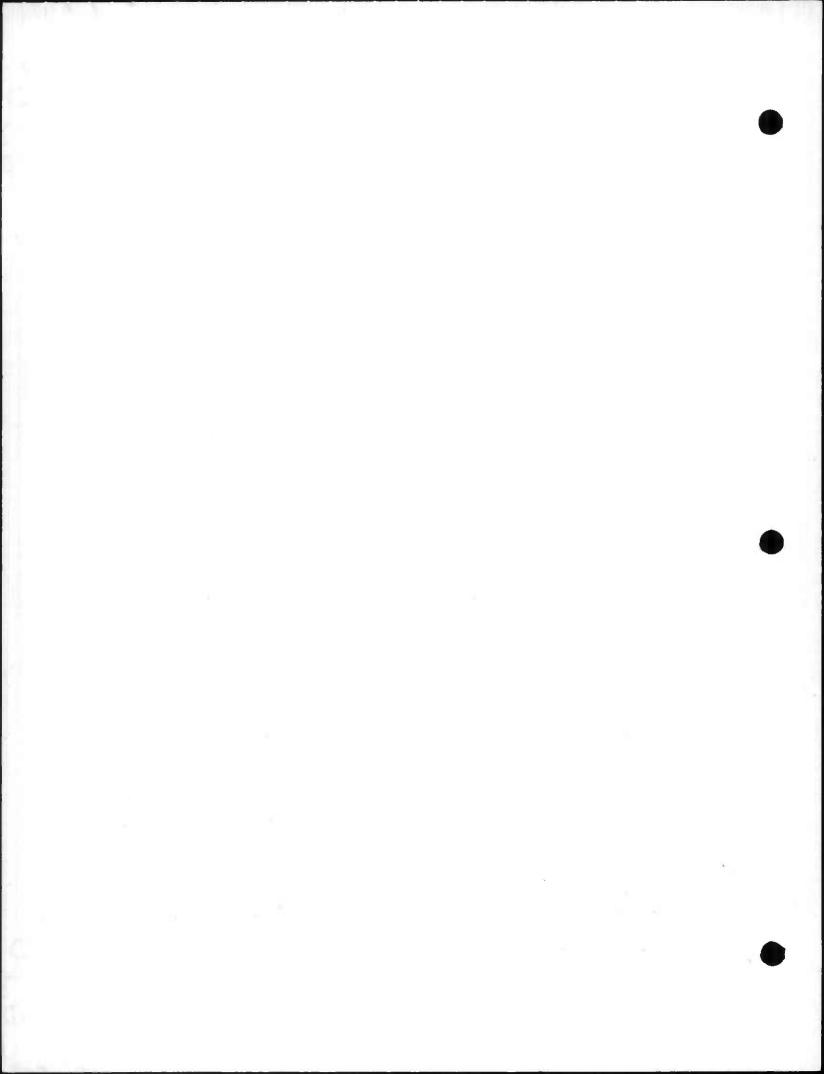
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Corra	Cora Revell 1 - STATE STATE STATE CF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR REGISTRAR													
	1. DECEDENT'S NAME (First, Middle, Last)									E OF DEATH		YEAR	3. TIME OF OEATH	
	CORA S	USIE	SIE REVELL						Sep	tember	7:45 P M			
	4. SOCIAL SECURITY NUMBER	5. SEX	st birthday)	_	R 1 YEAR		R 24 HRS.	7. DAT	7. DATE OF BIRTH 8,			BIRTHPLACE (State or Foreign Country)		
	214-10-9108	1 M 2 F	98	YRS.	MONTHS	MONTHS DAYS HOURS MIN.				December 24, 1896			arvland	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CIT	Y, TOWN C	OR LOCAT	ON OF D				ITY OF DI		
CTOR	SALISBURY NURSING & REHAB CENTER SALISBURY RESIDENCE OF DECEDENT										WICOMICO			
DIRECTOR	Maryland Wic	omico		10c. CIT		isbu						10d. INSIDE CITY LIMITS? 12 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 426 E. Vine St.		101. ZIP CODE 109. CITIZEN 2 180 1 USA								HAT COUNTRY?			
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No.— 14. RAC									14. RACE	E — American Indian.				
	TO THE MALL OF THE PARTY OF THE									Black	, White, etc.			
ВУ	3 Widowed 4 Divorced						2 10	Specif	y.		ŀ	Whit		
6	15. DECEOENT'S EDU (Specify only highest grade			CEDENT'S					10	Sb. KIND OF BUS	SINESS/INO	USTRY		
Щ	Elementary/Secondary (0-12)	College (1-4 or 5 +	lite	. Do NOT us	se retired.)	ouring mo	St OF WORK	ng						
MP	12			Iron	er					Laundr	y Sei	rvice	2	
COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First	, Middle, Malden				
ш	Jesse Messick						Su	sie			Mes	ssic	K	
10 B	19a. INFORMANT'S NAME (Type/Print)	_	19							mber, City or Town		,		
F	Ethel Tawes			687	7 Zi	on C	hurc	h Ro	l.,	Salisbu	ry,M	2 18	801	
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremellon 3 Removal from State 4 Donetlon 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parsons Cemetery 9/19 Salisbur													
	21. SIGNATURE OF FUHERAL SERVICE LIC	ENSEE	1 - 4-0	, , , , ,	22.	NAME AN	ID ADDRE	SS OF FA	CILITY		2000	-) , -		
	John 1	follow	an			501	Snow	Hil	1 Ro	Home I., Sal			21801	
	23. PART I. Enter the diseases, or shock, or heart fallure.	complications the	coused the de	eth. Do r	not enter	r the mp	de of dy	Ing, suc	h aa ce	rdiec or reapi	ratory err	est,	Approximate interval Between	
	IMMEDIATE CAUSE (Finei		1										Onset and Death	
	disease or condition resulting in death)	·	Pulare	0 1-	20 n	newi	713						MANY SPARE	
	1250 to 100 and 1	DUE TO	OR AS A CONSE	OUENCE OF	F):									
Z	Sequentially liet conditions,	b												
Ĕ	if any, leading to immediate ceuse. Enter UNDERLYING	DUE TO	OR AS A CONSE	OUENCE OI	F):									
CERTIFICATION	CAUSE (Disease or injury	C. DINE TO	OR AS A CONSE	OLIENCE OF	D.							-		
	that initiated events resulting in death) LAST	000 10	ON AS A CONSE	JUENCE OF	-):									
崽		d						_						
ایا	PART II. Other algnificent condition	e contributing to	deeth but not r	esuiting i	In the u	nderlylng	cause	given in	Pert I.			24b.	WERE AUTOPSY FINDINGS	
<u>ತ</u>	ADMANOS	Age	2							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICA	1172	Din	Seles							1 TYES 2	JE NO		OF DEATH? 1 ☐ YES 2 ☑ NO	
- N	DID TOBACCO USE CONTI	RIBLITE TO CA	USE OF DEA	TH YE	s \square	NO 18	LING	ERTAII	N [TES 2 PS NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	The state of the s		E OF DEAT) UITC	, LK I/(II						
잃	EXAMINER? 1 YES 2 NO	HOSPITAL:	FR/Outnation 3	C DOA	OTHE		. c (1 o	- aldana-		ner (Specify)				
¥	27. MANNER OF DEATH	28a. DATE OF	INJURY	26b. TIM	E OF	28c. INJ		INGONCE		EŞCRIBE HOW II	JURY OCC	URED		
	1 Natural 5 Pending	(Month, De	ly, Year)	INJ	URY M	WO	RK?	NO						
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O	INJURY — At ho	me, term, s	rtreet, fac				28f. LO	CATION (Street a	nd Number	or Rural R	oute Number.	
	4 Homicide determined	building,	atc. (Specify)						Cit	y or Town, State)				
9	29a. CERTIFIER	CIAN. To the best of												
COMPLETED	(Check only one) 1 CERTIFYING PHYSI MEDICAL EXAMINE												and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER													
BE	The State of the S		1110			ļ		O Q 1			29d. DATE	SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALL	E OF DEATH /ITE	M 27) (Sm-	Drine1		D-3	981	<u>J</u>			((0 (7 3	
						լարըը	INV	סח	c	ATTODE	IDV '	MD	21901	
_	MICHAEL R. ATI	87 SECISTAN	BISCOLOMATURO	4.11	пьн.	חדעו	IAV	DK.	, 5	WITOR	וואנ	עוני	21801	
3	31. DATE FILED SEIPO 2NO 1995	Jana	Constitution of the	- Cont										



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	2	20	=

	1220						95	Ú	1200		
	1 - FOR STATE REGISTRAR	STATE OF MARY	YLAND / DEPAR CERTIF	RIMENT OF H	DEATH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY	YEAR	3. TIME OF DEATH		
	Sarah Catherine	Tiutth				October 1		25	7:32 p M		
	220-03-9525	1 🗆 M 2 💢 F	74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan. 4, 19	(Country)				
TOR	9a. FACILITY NAME (N not institution, give stre Frederick Memori		1	Freder	CICK	EATH	Fred	deri			
DIRECTOR	10a. STATE 10b. COUNTY Maryland Frede	rick		y, TOWN OR LOCA ederick	TION			10d, INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 234 East Church	Street		10	21701	43	10g. CITIZEN OF W U.S.A.				
8	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	R IN U.S. ARMED ES 2 X NO R OATES	13. WAS DEC	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, atc.			
ED	15. DECEDENT'S EDUCA (Specify only highest grade or		16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDU	JSTRY	MILLEC		
APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sales	work done during mo ee retired.) Perso		Reta	ail				
BE COMPL	17. FATHER'S NAME (First, Middle, Lest) James	McI	aren, Sr.		18. MOTHER'S NA	ME (First, Middle, Malden rie Edith		fenb	erger		
10	19a. INFORMANT'S NAME (Type/Print) Gail Elizabeth Mc	Gowan				Pouts Number, City or Tow Arvada Colo					
	20a. METHOD OF DISPOSITION 1 Burlet 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)										
	21. SIGNATURE OF FUNERAL SERVICE LICE	Hul	M00255	Keene	ey and Ba	asford P.A.	. Fune	eral	Home		
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest.										
	ahock, pr heart failure. List only one cause on each line. iMMEDIATE CAUSE (Final disease or condition resulting in death) One A A CONSEQUENCE OF:										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PHYSICIAN: MEDICAL	PART II. Other aignificent conditions	contributing to deeth	but not resulting	in the underlying	g cause given in	Part I. 24a. WAS AN PERFOR	IMED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Z	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH YE	S 🗆 NO 🗆	UNCERTAIN	<u>-</u>			1 TYES 2 NO		
SIA	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	TH (Check only one)							
YSI		OSPITAL:	utpatient 3 🗆 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residenca	8 Other (Specify)					
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year			RK?	28d, DESCRIBE HOW II	NJURY OCCU	JRED			
	3 Suicide a Could not be 4 Homicide datermined	28e. PLACE OF INJU building, atc. (S	RY — At home, farm, specify)	reet, factory, offica 28t. LOCATION (Street and Number or Rus City or Town, State)				or Rural Ro	ute Number,		
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my kn							and manner as stated.		
BE	29b, SUMMATURE AND ATLE OF CERTIFIER	Stells			29c. LICENSE NUN	BER W/7//	29d. DATE	SIGNEO (Morfn, Day, Year)		
10	30. NAME AND AGORESS OF PERSON WHO O	COMPLETEO CAUSE OF	DEATH (ITILITIES) INDO	Print)	= ride	ul In	1d	12	21765		
	31. OATE FILED (MORITH, Day, Yell) OCT 0 6 1995	32. BEGISTRAR'S SH	ELECK-RENDELLA								



permit. Pages 1, 2, 3 should

Carl Bianco, M.D.
31. DATE FILEO (Month, Day, Voer)
OCT 0 3 1995

M.D.

300 Byrn Street

											95	3	1290
		FOR 1 - STATE REGISTRAR	STATE OF I			RTMENT OF H			MENTA		IE		The second second
		1. DECEDENT'S NAME (First, Middle, Last)			-NIII	ICATE OF	DEA	In		REG. NO) <u>. </u>		
		The second of the live is the second second	Pacho1	Sonya Sa	ndoo				MONY		MY	YEAR	3. TIME OF DEATH
										ober	2, 1	995	10:57 a M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 YEAR	HOURS			OF BIRTH		8. BIRTHI	PLACE (State or Foreign
		577-46-8358	t M 2XXF	59	YAS.	MONTHS DAYS	HOURS	MIN.	March 3 1936 Wa			Wash	ington D.C.
		9a. FACILITY NAME (If not institution, give	street and number)			96. CITY, TOWN	OR LOCATI	ON OF DE	EATH		9c. COUR	ITY OF DE	НТА
g	5	Dorchester Ge	neral Hos	spital		Camb	rido	_			Dor	ches	tor
Ĕ	5	RESIDENCE OF DECEDENT		3PI OGI		Camb	11480				DOI	Cires	CEI
DIRECTOR		tos. STATE 10b. COUNT				Y, TOWN OR LOCA							10d. INSIDE CITY LIMITS?
		Maryland D	orcheste	r		1109 Ham	brool	k Boı	uleva	ard,	Cambr:	idge	LIMITS? 1 X YES 2 NO
■		toe. STREET AND NUMBER					. ZIP COD				7		HAT COUNTRY?
1 2		1109 Hambroo	k Bouleva	ard			216	513			U.	S.A.	
FUNERAL		11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS DEC	ENDENT (OF HISPAN	NC OBIGII	Y? (Specify Ye			- American Indian
II.	-	1 Never Married 2 XXMarried	FORCES? 1	YES 2 X	10	If yes, sp	ecify Cubs	n, Maxica	n, Puerto	Rican, etc.)	1111/12/20		— American Indian, White, etc.
≥		3 Widowed 4 Divorced	11 120, 0112	att off dates		T TES	2)(XNO	Specify	y:			Specify	white
G	1	15. DECEDENT'S EDU				USUAL OCCUPATION			168	. KIND OF BU	SINESS/IND	USTRY	
		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	tite.	ive kind of Do NOT u	work done during mo se retired.)	st of working	ng					
_ <u>_</u> _		12	2		retai	rial, cl	erica	a1		gener	al ho	snit:	a1
COMPLET		17. FATHER'S NAME (First, Middle, Lest)				101, 01			MF /First	Middle, Maiden		opr c	a.r
		Phili	p Notes	3								ffri	n
BE		i builded building											
2	2	John E. Sandoe 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Hambrook Blvd., Cambridge Md. 21613											
9		20a. METHOD QF PISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town. State											
5		1 Burfel 24 Cremation 3 Removal from State 20b. PLACE AND DATE of PISPOSITION (Name of company). Crematory or other place) Salisbury Maryland Sali											
	-	21. SIGNATURE OF FUNERAL SERVICE LI		Salis	Dury					Sal	isbur	y Ma:	ryland
		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			Thom:				O.M.O.			
5		1 meth	& Tho	man of	,					ambrid	ao MD	216	1.2
		23. PART I. Enter the diseases, or	complications the	t caused the de	ath. Do i	not anter the mo	de of dy	ing, suci	h an can	diac or reap	iratory arm	eat.	Approximata
		shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death											
		disease or condition											Onset and Death
		resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): years											years
		DUE TO (OR AS A CONSECUENCE OF):											E
CERTIFICATION		Sequentially list conditions, July 100 As a conscouence on:											5 years
A		cause. Enter UNDERLYING Type I Insulin dependent diabetes											
		CAUSE (Disease of Injury											years
		that initiated events resulting in death) LAST d. Atypical Hyperlipidemia											20 years
			d ALYPIC	ar hyper	ттЪт	delita							20 years
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS											
MEDICAL										PERFO	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
										1 TYES 2	Z-NO		OF DEATH?
Σ		DID TOBACCO USE CONT	DIDLITE TO CA	LICE OF DEA	TII VI	C D NO F	C 11110	EDTAIL				Ч	t YES 2 NO
PHYSICIAN:			KIBUTE TO CA				UNC	ERTAIN	и Ц				
길		25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
S≥		1 VES 2 TO NO 27. MANNER OF DEATH		LER/Outpatient 3		4 - Nursing Hom		esidence					
6 1	- 10	1 Natural 5 Pending	28e. DATE OF (Month, D		28b. TIM	URY WO	RK?		28d. DES	CRIBE HOW I	NJURY OCC	URED	
B		2 Accident Investigation					rES 2	NO					
0		3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE C building,	etc. (Specify)	me, ferm, :	street, factory, offic	•		28f. LOC City	ATION (Street or Yown, State)	and Number	or Rural Ro	oute Number,
PL		290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge, de	ath occum	ed at the time, data	and place	, and due	to the car	ree(s) and ma	nner as state	ıd.	
COMPLET		one) 2 MEDICAL EXAMINE											and manner as stated.
		29b. SIGNATURE AND MILE OF CERTIFIE			_			ENSE NUM					
H		(a.1	Sum	D 44	\cap				-UCM				Month, Day, Year)
P P		30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALL	SE OF DEATH //TEN	1 277 /5	Drint)	D32	219			Oct	ober	2, 1995
1.1	- (1)	OF PERSON WE	- COMPLETED GAU	OF DEATH (ITER	n 41} (1)/pe,	runj							

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Cambridge, MD

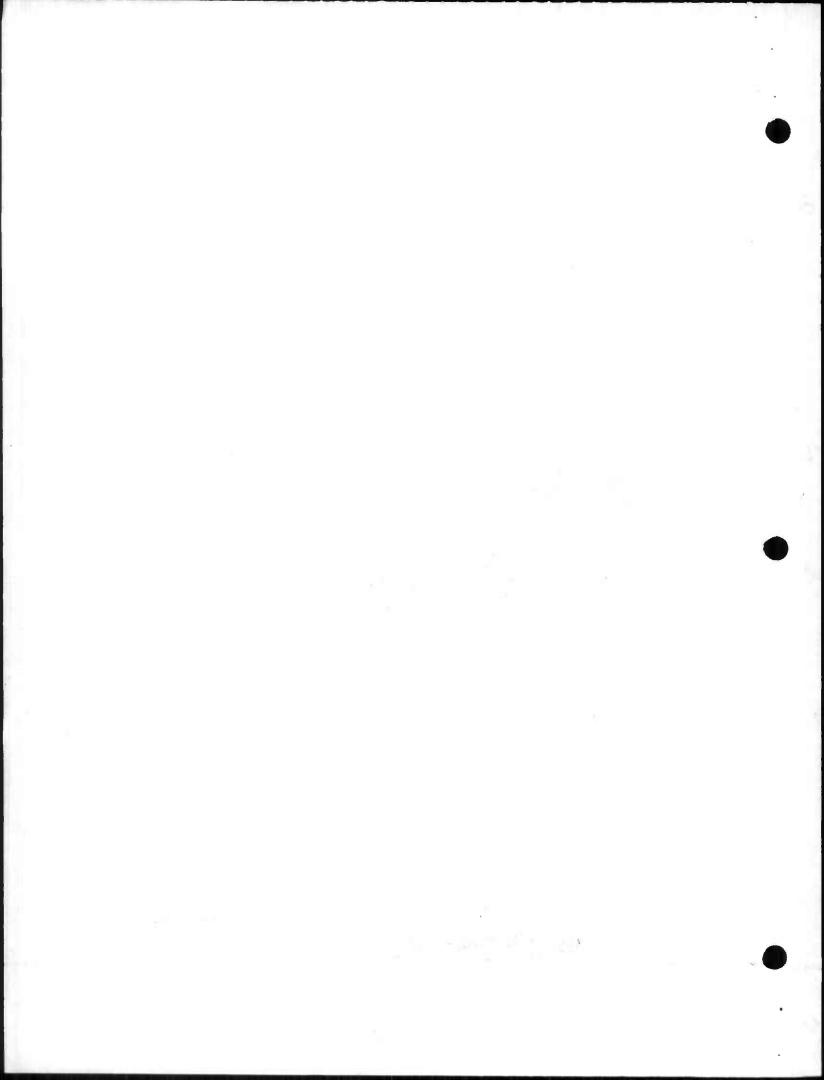
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within z ⁴⁶ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. In the first permit after death with the State Degly, of Health and Mental Hygiere prior to burial, cremation, or removal. **IMMORPHAT** If them 28 is marked or them 23 shows any Intury or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1.

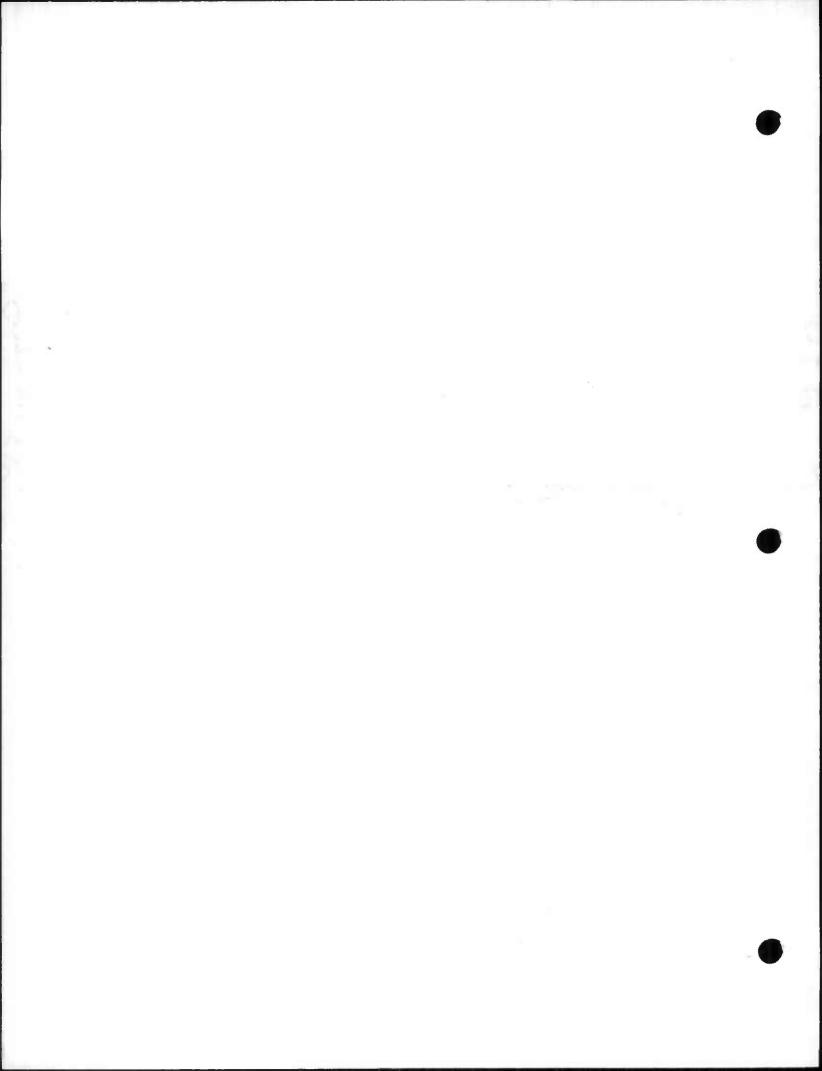
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE OF MONTH	DEATH	,	YEAR	3. TIME OF DEATH	
	CHARLES			W.		S	KIN	NER, II	SEPTE			995	9:32P	М
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	s. last birthday	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTN			PLACE (State or Forei	ign
	221-32-7244		1 🔀 M 2 🗆 F	46	YRS.	MONTHS	DAYS	HOURS MIN.			1948		mington.	DE
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)		9b. CITY,	TOWN C	R LOCATION OF DE				NTY OF D		1/15	
DIRECTOR	THE JOH		PKINS HOS	PITAL		BALTIMORE CITY								
EC	10a. STATE	10c. C	ITY, TOWN O	R LOCAT	ION					10d. INSIDE CITY				
	Delaware	New C	astle		Wilmington						LIMITS? 1 YES 2			
A	10e. STREET AND NUMBER						101	. ZIP CDDE			10g. CIT	IZEN OF V	VHAT COUNTRY?	
FUNERAL	1405 Ivy Di	ive						19803			1	JSA		
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S	S. ARMED			ENDENT OF NISPAN			or No-	14. RACI	E — American Indian, k, White, etc.	
BYF	1 Never Married 2 3 Wildowed 4 Divo		FORCES? 1 IF YES, DIVE W	AR DR OATES	3			2X ND Specify		ri, arc.,		Spec		
COMPLETED	15. DEC	EDENT'S EDU	CATION COMPRISED	164	DECEDENT	'S USUAL O	CCUPATIO	ON et of working	16b. KII	ND OF BUS	INESS/IN	DUSTRY		
Ē	Elementary/Secondary (6	- 1	College (1-4 or 5	+)	Iffe. Do NOT	use retired.)								
APL			3	Me	edical	. Tech	nnic	ian	Me	dical	l			
Ö	17. FATHER'S NAME (First, M							18. MOTNER'S NA			Surname)			
BE C	Charles R.	Skinne	er					Ileene	B. Ti	11				
TO B	John G. Ishi						,	nd Number or Aural			, State, Zi L 980.			
	20e. METNOD OF DISPOSIT								OATE	,			own, Stata	
	1. Buriel 2 X Cremetic 4 Donation 5 Other	n 3 X Rem	ioval from State	cemeter	ACE AND DAT y, cremetory or matory	other place) Com	Hoc	kessin	Oct.4	New	Casi	tle.	DE	
	21. SIGNATURE OF NUMERIA	L SERVICE LIC	CENSEE	7		22.	NAME A	ND ADDRESS OF FA	CILITY Ch	and1e	er Fu	inera	1 Home	D
	2506 Concord Pike, Wilmington, DE 19803 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											3		
CERTIFICATION	shock, or heert feliura. List only one cause on each line. Interval Batween Onset and Daeth Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated aventa resulting in death) LAST. Due to (or as a consequence of): Due to (or as a consequence of):													
ER	resulting in death) LAST													
MEDICAL C	PART II. Other algorifica	ant condition	ne contributing to	not resulting in the underlying cause given				Part I. 24a. WAS AN AUTOPSY PERFORMED?			248	. WERE AUTOPSY FINE MAILABLE PRIOR TO COMPLETION OF CAP OF DEATH?	USE	
	DID TODA CCO I	ICE CONT	DIDLITE TO CA	LICE OF F	DEATH Y	/FC 🗀 1	Tal	LINICEDIAL					1 TYES 2 NO	
N	DID TOBACCO U		KIBUIE IO CA		PLACE OF OR			UNCERTAI	иП					
PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO	O MEDICAL	HOSPITAL:			OTHE	R:	ne 5 🗆 Residence	6 Other (S	loeclfv)		_	159	
H	27. MANNER DF OEATH		28e. DATE OF	INJURY	28b. T	IME OF	26c. IN.	JURY AT	26d. DESCR		NJURY OC	CURED	22	
		Pending Investigation	(Month, L	ray, rear)		NJURY M		YES 2 ND						
ETED BY	2 Accident 3 Suicide 8 4 Homicide	Could not be determined	26s. PLACE (building	OF INJURY — . atc. (Specify)	INJURY — At home, farm, atreet, factory, office			•	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
E	29a. CERTIFIER						_							
COMPL	(Check only		ER: On the best of a										s) and menner as sta	ted.
	29b. SIGNATURE AND TITLE	MY CERTIFIE	P.					29c. LICENSE NU	MBER		29d. DA	TE SIGNE	(Month, Day, Year)	_
BE	Man &	te o	ob MI					1/251) /		15		he 30 10	05
	LULINO U	need	EMED 1 1 1.		N250/						PENTEUN	IPP 7 1 1 / 7'	7 1	
5	30. NAME AND ADDRESS O	F PERSON WI	HD COMPLETED CALL	SE DF OFATH	(ITEM 27) /5	roe. Print		7,7	-			The Contract	00 30/11	10
	5 taven Du	dek. A	M.D. J	Ohns	HODI	pe, Print) Kins	HO 51	pital E	Balti	more	Ma	14/4	nd, 2121	25



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR					ICATE C		LTH AND N		H YGIENI REG. NO.	E		
	1. DECEDENT'S NAME (Firs	t, Middle, Last)				TOATE C	71 01	LAIN	2. DATE OF				. TIME OF DEATH
	Ruth An	n Sp	otswood						MONTH Septer	DA		YEAR	0415 ам
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1 YE		UNDER 24 HRS.	7. DATE OF	BIRTH	1	9. BIRTHP	ACE (State or Foreign
	219-07-8375		1 M 2 X F	75	YRS.	MONTHS DA	VS HO	DURS MIN.	March	15.	1920	Country) Mar	vland
	9a. FACILITY NAME (If not is	nstitution, give s	treet and number)			9b. CITY, TO	WN OR LO	OCATION OF DE				ITY OF DE	7
стов	Union Hospi	tal of	Cecil C	ounty		E	1kto	on			(Cecil	
[[RESIDENCE OF DE	10b. COUNT	1		10c CIT	Y, TOWN OR LO	CATION					T	Od. INSIDE CITY
DIRE	Maryland		Ceci1					East					LIMITS?
AL I	10e. STREET AND NUMBER		OCCLI			NO	10f. ZIP				10a CITI		YES 2 NO
E	238 Red T	oad Ro	ad					2190	3.1		100		tates
FUNER	11. MARITAL STATUS		12. WAS DECEDEN			13. WAS	DECEND	DENT OF HISPAN		Specify Yes	_		
B≺	1 Never Merried 2 3 Widowed 4 Dive		FORCES? 1	YES 2 X	NO			Cuban, Mexican NO Specify:	nn, Puerto Rican, etc.) Black, White			White wic. White	
9	15. DEC (Specify on	EDENT'S EDU	CATION completed)			USUAL OCCUP		Lumakina	16b. Ki	ND OF BUS	INESS/IND	USTRY	
	Elementary/Secondary (College (1-4 or 5	- 44	Do NOT ut	e retired.)	g most of	working					
COMPLET	12			Wai	itres	S				Rest	auran	ıt	
8	17. FATHER'S NAME (First, A	,					100	. MOTHER'S NAM			Sumame)		
BE	Walter Boul							Grace I					
2								Number or Rural R					
	Paul R. Spo					20 Biggs Highway, North East, MD 2							
	1 Surial 2 Crematil	on 3 🗆 Rem	oval from State	cemetery, co	ematory or o	ther place)		of	OATE				
	21. SHONATURE OF FUNDA		Angue 2	Roser	ank	Cemete:		DDRESS OF FAC	9/27	Car	vert,	Mar	yLand
	1/0/14	111	4			Cro	ıch	Funeral	L Home				
\vdash	23. PART I. Enter the d	712				127	Sou	th Mair	Stre	et, l	North	Eas	t, MD 2190
:ICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CUA, CAO lactic as dos dosis Due to (or as a consequence of): Comparation of the conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Pleases or Indian) CAUSE (Pleases or Indian)										Interval Batween Onset and Death		
CERTIFI	that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDIN												
EDICAL.	PART II. Other algorifica	ant condition	s contributing to	daath but not	resulting	n tha underi	ying ca	uaa given in F		PERFORI	MED?	A	TERE AUTOPSY FINDINGS WARLABLE PRIOR TO OMPLETION DF CAUSE F OEATH?
Σ	DID TOPACCO I		DIDLITE TO CA	USE OF DEA	TH VE		П	UNCERTAIN				'	YES 2 NO
اللعال	UD IODACCO U	ISE CONTI	CIDUIT IU LA			SIINO							
AN	25. WAS CASE REFERRED T		RIBUTE TO CA			H (Check only o		DITCERIAIT			_		
AN.			HOSPITAL:	26. PLA	CE OF DEAT	OTHER:	one)		Other (S	neoffs)			
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TED BY PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Accident	O MEDICAL Pending	HOSPITAL: 1 Nopetient 2 28a. DATE OF (Month, D) 28a. PLACE O	26. PLA: ER/Outpetlent : INJURY ny, Year)	DOA 28b. TIM	OTHER: 4 Nursing i E OF 28c. URY M 1	Home 5 HOME 5 HOJURY WORK? YES	☐ Residence €	28d. DESCR	IBE HOW IN			te Number,
TED BY PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Action 2 Accident 3 Suicide 8 Hornicide	Pending Investigation Could not be detarmined	HOSPITAL: 1 Copetient 2 2 28a. DATE OF (Month, D) 28a. PLACE O building,	26. PLAI ER/Outpetient : INJURY ny, Year) F INJURY — At he etc. (Specify)	DOA DOA NOTICE, term, a	OTHER: 4 Nursing I E OF URY M 1 street, factory, o	Home 5 HOME 5 HIJURY WORK? YES	Residence 6 AT 2 NO	28d. DESCR 28t. LOCATIO City or 1	DN (Street ar	nd Number (or Rural Rou	te Number,
MPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29a. CENTIFIER (Check only)	Pending Investigation Could not be detarmined	HOSPITAL: 1 Vinperlent 2 28s. DATE OF (Month, D) 28s. PLACE O building.	26. PLAI ER/Outpatient : INJURY ; y, Year) F INJURY — At he etc. (Specify) my knowledge, de	DOM 28b. TIM INJ	OTHER: 4 Nursing I E OF URY M 1 streat, factory, 6	Home 5 HJURY WORK? YES	Residence 6 AT 2 NO	28t. LOCATION Of the cause(DN (Street ar bwn, State)	nd Number (or Rural Rou	
COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29a. CENTIFIER (Check only)	Pending investigation Could not be determined	HOSPITAL: 1 Department 2 2 28a. DATE OF (Month, D) 28a. PLACE O building. CIAN: To the best of R: On the beste of at	26. PLAI ER/Outpatient : INJURY ; y, Year) F INJURY — At he etc. (Specify) my knowledge, de	DOM 28b. TIM INJ	OTHER: 4 Nursing I E OF URY M 1 streat, factory, 6	Home 5 INJURY WORK? YES office	AT 2 NO place, and due to occured at the to	28d. DESCR 28t. LOCATION Of the cause (ime, data and	DN (Street ar bwn, State)	nd Number of	or Rural Rou d.	nd menner as stated.
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BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29a. CERTIFIER (Check only one) 1 29b. SIGNATURE AND TITLE	Pending investigation Could not be detarmined TIFYINO PHYSI ICAL EXAMINE F PERSON WHI	HOSPITAL: 1 Nopellent 2 2 28a. DATE Of (Month, D) 28a. PLACE O building, CIAN: To the best of a: 3 0 COMPLETEO CAUS	26. PLAN ER/Outpatient : INJURY my, Year) F INJURY — At he etc. (Specify) my knowledge, determination and/or	DOM 28b. TIM INJ DOME, term, seath occurre investigation M 27) (Type,	TH (Check only of OTHER: 4 Nursing I BOF 28c. URY M 1 I Street, tectory, of the time, in, in my opinion of the time, in my opini	Home 5 INJURY WORK? YES office	Residence 6 AT 2 NO pleca, and due to occured at the toc. LICENSE NUM	28d. DESCR 28t. LOCATION Of the cause (Irre, data and BER	ON (Street arown, State)	nor as state due to the 29d, DATE	or Rural Round. d. cause(a) a SIGNEO (A	nd menner as stated.



BALTIMORE, MARYLAND 21215-0020	death. Page 6 may be retained by the hospital or attending physici	funeral director, page 5 should be detached for use as the burial-
8	24 hours after	filled in by the
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physici	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hural-

trending physician.

e as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)						04/1		2. DATE OF	DEATN			3. TIME OF DEATN
	Maria					Oct.	DV		YEAR	3:15 AM				
	4. SOCIAL SECURITY NUME	BER	Sprigg 5. SEX		s. leat birthday	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTH	17	0. BIRTN	IPLACE (State or Foreign
	215-16-02	15	1 M 2 K F		7 4 YRS.	MONTHS							"	
	Ba. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN							
0 8	Anne Arun	del M	led. Ctr	2,		A	Annapolis					ne A	rundel	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	1		100 0									
E	MD		e Arund	101	100.0			a Pa	1-					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	AIIII	e Alumo	rer		sev		a Pa				10a CIT	TIZEN OF V	1 ☐ YES 2 ☑ NO
FUNERAL	518 Everg	reen	Rd.					1777	146					THAT COUNTRY?
S	11. MARITAL STATUS	reen	12. WAS DECEDEN	IT EVER IN U.S	ARMED	13.	WAS DEC			IIC ORIGIN? (S	pecify Yea	U.S		— American Indian.
BY F	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 3 Widowed 4 Divorced IF YES, OIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify:										t, White, atc.			
	W moved 4 Divided										White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 100. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOME HOME													
J.E														
MC	17. FATHER'S NAME (First, M	licicitio (net)			Hom	emak	er							
BE	19a. INFORMANT'S NAME (7)				19b. MAILIN	G ADDRES	S (Street a			Route Number,			in Code)	
욘	Roy Sprig	gs								rnold				1
	20a. METHOD OF DISPOSIT	ION		20b. PLA	CE AND DATE	OF DISPO	SITION (Na		J	DATE		_	City or To	wn. State
	1 3 Burial 2 Crematic 4 Donation 5 Other	(Specify)		_ cametery M D	Vete	other place,	Ce	m .	10	14				le, MD
	21. SIGNATURE OF FORESTA	LYMERVICE LIC	EHERE.			22.	NAME AP	D ADDRE	SS OF FA	CILITY				
	MA 1	40	Sum		-					Sons				
	23. PART /. Enter the di	lseases, or o	omplications tha	t caused the	death. Do	not enter	the mo	de of dy	ing. such	HWY .	or respir	vern	rest.	ark MD 2114
	ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Daath										interval Batween			
	disease or condition resulting in death)										Onset and Daath			
	DUE TO/OR AS A CONSEQUENCE OF)													
Z	Sequentially list conditi	lone C	(arl	Lom	400	200	ly						
ATIC	if any, leading to immed cause. Enter UNDERLYI	diata	DUE YO	(OR AS A COR	VSEQUENCE (7		1						
CERTIFICATION	CAUSE (Disease or Inju		DUE TO	(OR AS A COR	ISEQUENCE I	NE)								
H	resulting in death) LAS	т			THE STATE OF									j i
S														1
¥	PART II. Other algorifica	nt cordition	s contributing to	death but n	at resulting	in the ur	nderlying	Canha (given in	Part 1. 24	PERFOR		246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	CAPA	1/1000	1.12/411	Way	//	-/-	this	10			YES 2	No.		COMPLETION DF CAUSE OF DEATH?
Σ	<u> </u>	COOPE	Kill ond	ed rout	core	-	- C	NO		_	- 4			1 - YES 2 - NO
Z	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		LACE OF DEA	OTHER	R:							
₹	27. MANNER OF DEATH		18s. DATE OF		25h, Til		28c. INJ		reidence	E Cother (Sp	-	a manner about	an mann	
	1 Netural 5 🗆	Pending	(Month, D			JURY	WO	RK7	TNO	28d. DESCRI	BE HOW IN	MUNY OC	DUMED:	
BY	a Clauses	Investigation Could not be	284. PLACE O	F INJURY A	t home, farm,	street, fact			1110	zer. LOCATIO	N (Street is	nd Number	or Bursi B	nute Mumber
ED	and the second s	determined	building,	etc. (Specify)						City or 10	wn, State)			2
LET	29s. CERTIFIER 1 CERTI	TEYING PHYSIC	CIAN: To the best of	my knowledge	death occur	rad at the t	lime data	and place	and due	to the council	s) and area			
COMPL	Oghi 2 MEDI	EAS EXAMINE	R: On the basis of as	amination and	l/or investigati	on, in my o	opinion, d	eath occur	ed at the	time, data and	place, and	dua to th	ied. he cause(a)	and menner as stated.
	299 SIGNATURE AND TITE	4		1					INSE NUM					
H	(brush d)	1/1/40	lov bus 1	Hor in	do		1	Di	41	62		290, DAI	In 7	(Month, Day, Year)
٩	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH	ITEM 27) (Typ	s, Print)		11	1 10	1		1	11	43
			rder.	mo	/	300	Ki	tole	0/	Yw.	1	na	1.11	NH 21012
	31. DATE FILED (Month, Day,	5º4 05	42 REDISTRA	T'S SIONATUR	E, 0	4			-	-	11/4	, -0	101	7
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31. DATE FILED (Month, Day, Year)

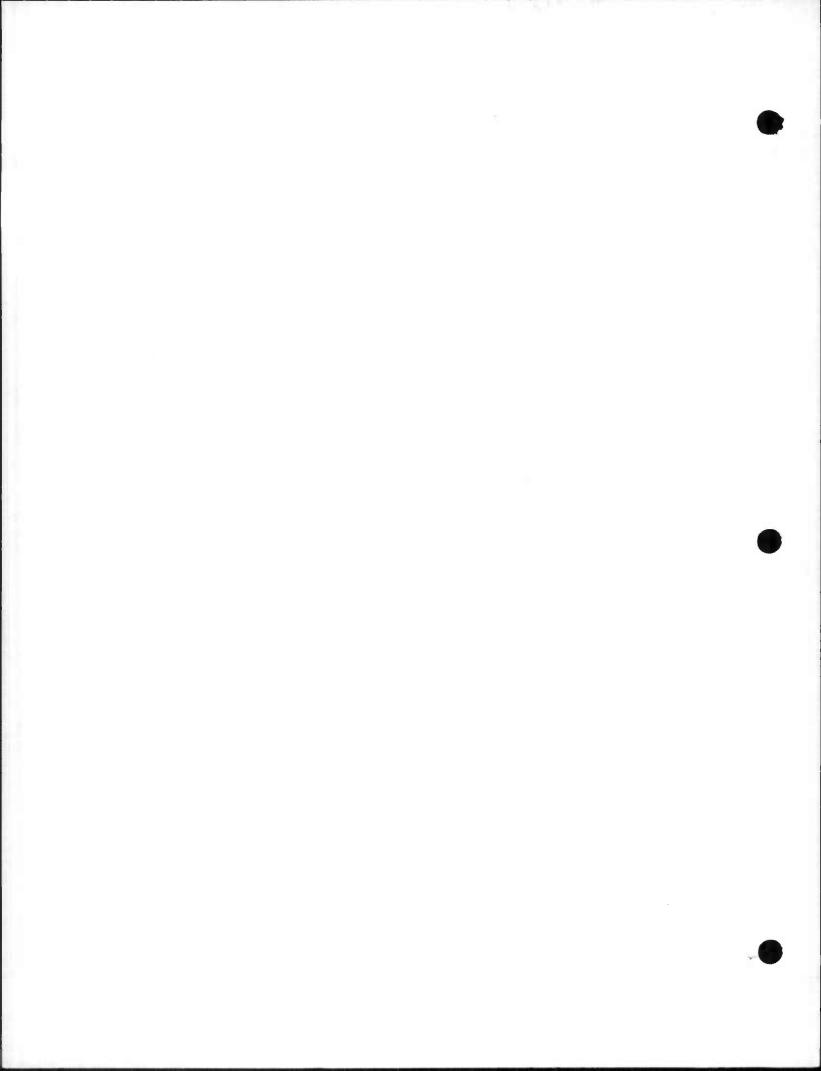
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH 2. DATE OF DEATH 3. TIME OF DEATH CLARA STEUART 1995 An 4 30 September 8:00 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) Jan 9 1913 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 215-05-7638 1 M 2 X 82 YRS. Waryland hours after death. Page 6 may be retained by the hospital or attending physician. et in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2678 Cunningham Hote Road Annapolis Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? ND Anne Arundel Annapolis 1 TES 2XXNO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2678 Cunningham Hole Road 21401 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried Specify: White BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY
Federal Government/ (Specify only highest gi (Give kind of work done ife. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Office Wanager National Labor Relations once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) Albert Schultz notified at Clara Hogan BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Gordon Steuart 2678 Cunningham Hole Road Annapolis, MD 21401 9 20e. METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State must Lincoln Crematory 10/2/95 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE medical examiner 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis. MD 23. PART 4. Enter We disasses, or complications the caused the des shock, or heart failure. List only one cause on each line. caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 6 filled IMMEDIATE CAUSE (Finel **Onset and Death** the th cremation. executed within 24 disesse or condition MIC OBEHOUSTOP LUM DILENE completely resulting in death) traumatic event, burial. ALASIA CERTIFICATION this certificate has been signed by the attending physician and next the State Dept, of Health and Mental Hygiene prior to burn Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury DUETO (OF AS A CONSEQUENCE OF) other t that initiated events resulting in death) LAST 0 the death Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY that shows any 1 YES 2 NO requires OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES 🕅 NO 🗌 UNCERTAIN 🔲 AMP. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The Hem HOSPITAL: 1 YES 2 NO OTHER OR ATTENDING PHYSICIAN: 1 Inpetient 2 ER/Outpetient 3 DOA Home 5 Residence 8 Other (Specify) the 6 27. MANNER OF DEATH 28e. OATE OF INJURY 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident M BY Investigation 1 YES 2 NO FUNERAL DIRECTOR: After t within 72 hours after death 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 90 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide Hem CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho HOSPITAL beele of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and menner ee stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 0 2 900 BEST 32. REGISTRAR'S SIGNATURE

Davidson Rardall

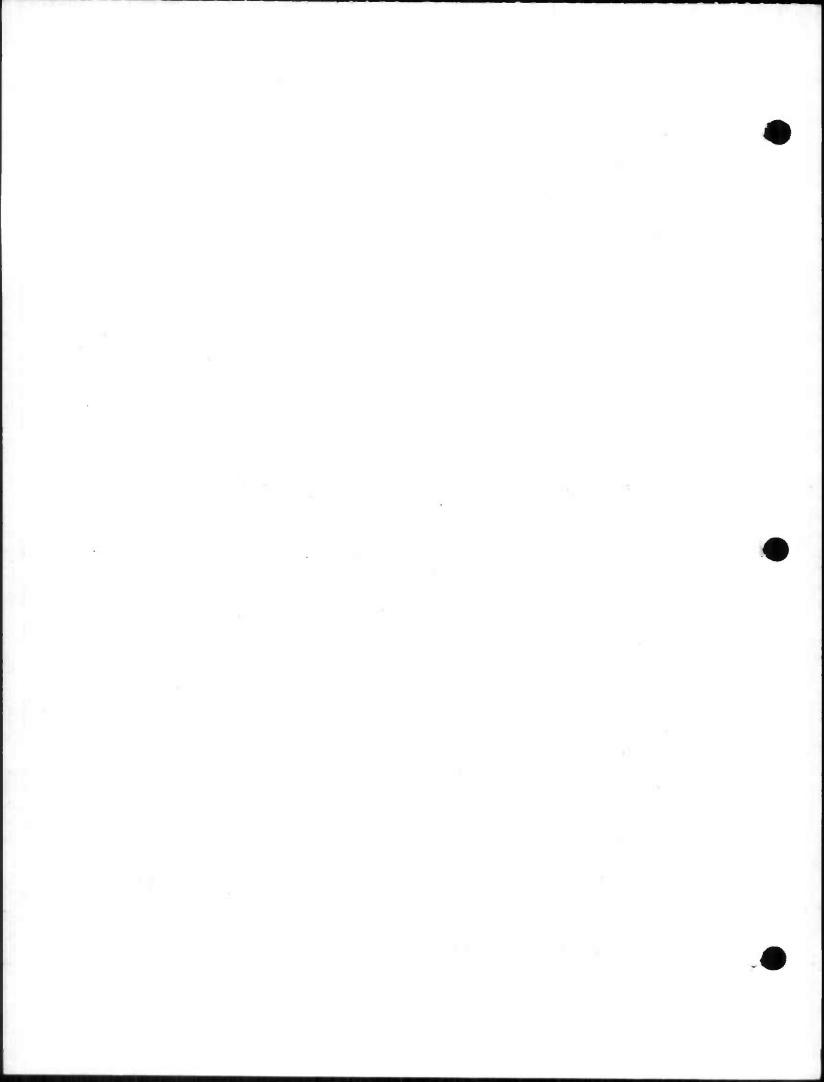
71401



DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	-UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.	STANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPIT	TO THE FUNERA	be filed within 7	IMPORTANT: I

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND		MENT OF H			GIENE				
	1. DECEOENT'S NAME (First, Middle, Last)			7112 01		2. DATE OF DE		YEAR	3. TIME OF DEATH		
	SANDRA LE	EE SPOO)				er 18, 19		11:14 a ^M		
- 1		SEX 6. AGE (In yrs. I	- 1	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BII (Month, Day,	PLACE (State or Foreign y)				
ì	103 10 1370	□ M 2 🔀 F 50	YRS.		17.200	August 9			nsylvania		
œ	99. FACILITY NAME (If not institution, give street of 7380 Gumboro Rd.,				r location of de		1,000	Omi			
DIRECTOR	RESIDENCE OF DECEDENT	Apt. 23			ICCSVIII	Le	Wicomico				
RE	10e. STATE 10b. COUNTY			TOWN OR LOCA				10d. INSIDE CITY LIMITS?			
		omico	Pit	tsville			10a CC	FIZEN OF W	1 X YES 2 NO		
100. STREET AND NUMBER 7 380 Gumboro Rd., Apt. 23 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or If yes, specify Cuben, Mexicen, Puerto Ricen, stc.)									THAT COUNTRY?		
N N	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S. A			ENDENT OF HISPAN			- American Indian,			
7	1 Never Married 2 Merried	FORCES? 1 YES 2 1 F YES, GIVE WAR OR DATES	₫но		ecify Cuben, Mexice 2 X NO Specify		stc.)	Speci	r, White, stc.		
B √	3 Widowed 4 Divorced					I I I I I I I I I I I I I I I I I I I		Whi	te		
TED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	oleted)		SUAL OCCUPATION done during more retired.)		16b. KIND	OF BUSINESS/IN	IDUSTRY	100		
7	Elementery/Secondary (0-12) Co	ollege (1-4 or 5+)	Cook			Ro	stauran	-	100		
COMPLET	17. FATHER'S NAME (First, Middle, Lest)		OOOK		18. MOTHER'S NA						
BE C	Reuben Samuel Cl	entimack			Harrie	et Mab	le McNe	eal			
2	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural I				MD 01050		
-	George Krause								MD 21850		
	20e. METHOO OF DISPOSITION 1 Burlel 2 X Cremetion 3 Remove	from State cemetery, o	crematory or othe	DISPOSITION (N		i	20c. LOCATION -				
	4 Donotion 6 Other (Specify) Salisbury Crematory 9/21 Salisbury, MD 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home										
	D/11Ph/0	1							vn 21001		
\dashv	23. PART I. Enter the diseases, or comp	olicetions the caused the	death. Do no		Snow Hi				MD 21801		
	ahock, or heart failure. List	only one centre on each il	ne.					,	Intervel Between Onset and Death		
	IMMEDIATE CAUSE (Finel disease or condition		marta								
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Servere debilitation / Aspiration Due to (or as a consequence of):										
z	b	metast	atic	Can	cer				months		
E	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury)										
CERTIFICATION	CAUSE (Disease of injury	DUE TO (OR AS A CONS	SEQUENCE OF):	ario	1, 1, 1, 1, 1						
	thet initiated events resulting in death) LAST										
- 1	PART II. Other aignificant conditions of	patributing to death but se	t requiting in	the restories	a cause alvea la	Bart I 24a	. WAS AN AUTOPS	/ 244	. WERE AUTOPSY FINDINGS		
B	PART II. Other argumeant conditions of	Anti-botting to death but no	it resolving in	the underlyin	å cense diveri ili		PERFORMED?	240	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
						_ 1	YES THO		OF DEATH?		
Σ	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DE	ATH YES	□ NOT	UNCERTAI	N 🗆			1 123 24 10		
IAN	25. WAS CASE REFERRED TO MEDICAL	26. PL	ACE OF DEATH	(Check only one	1						
SIC		OSPITAL: inpstient 2 ER/Oulpatient		OTHER: I Nursing Hor	ne 5 🗆 Residence	6 Other (Spe	ecify)				
PHYSICIAN: MEDIC	27. MANNER OF DEATH 19 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU		JURY AT DRK? YES 2 NO	28d. DESCRIB	BE HOW INJURY O	CCURED			
ВУ	2 Accident Investigation 3 Suicide S Could not be	28e. PLACE OF INJURY — At	home, ferm, str	reel, factory, offi			N (Street and Numb	er or Rural	Route Number,		
S Could not be building, stc. (Specify) City or Town, State City or Town, State											
29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(e) end manner ee stated. (Check only 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(e) end manner ee stated.											
									e) end manner ee stated.		
ш	296 SHORADUME AND TITLE OF CERTIFIER	1 .01	7		29c. LICENSE NU	MBER	29d. D	TE SIGNED	(Month, Day, Year)		
TO B	9 Mura	- WIL			D 4	548	5 17	121	1/95		
E 1	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OEATH (I	TEM 27) (Type, f	Print)							
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURI	E	-:							
	SEP 22 1995	Julia Davidson	Rardall								
	<u> </u>	0						_	DHMH-t6 Rev t/89		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

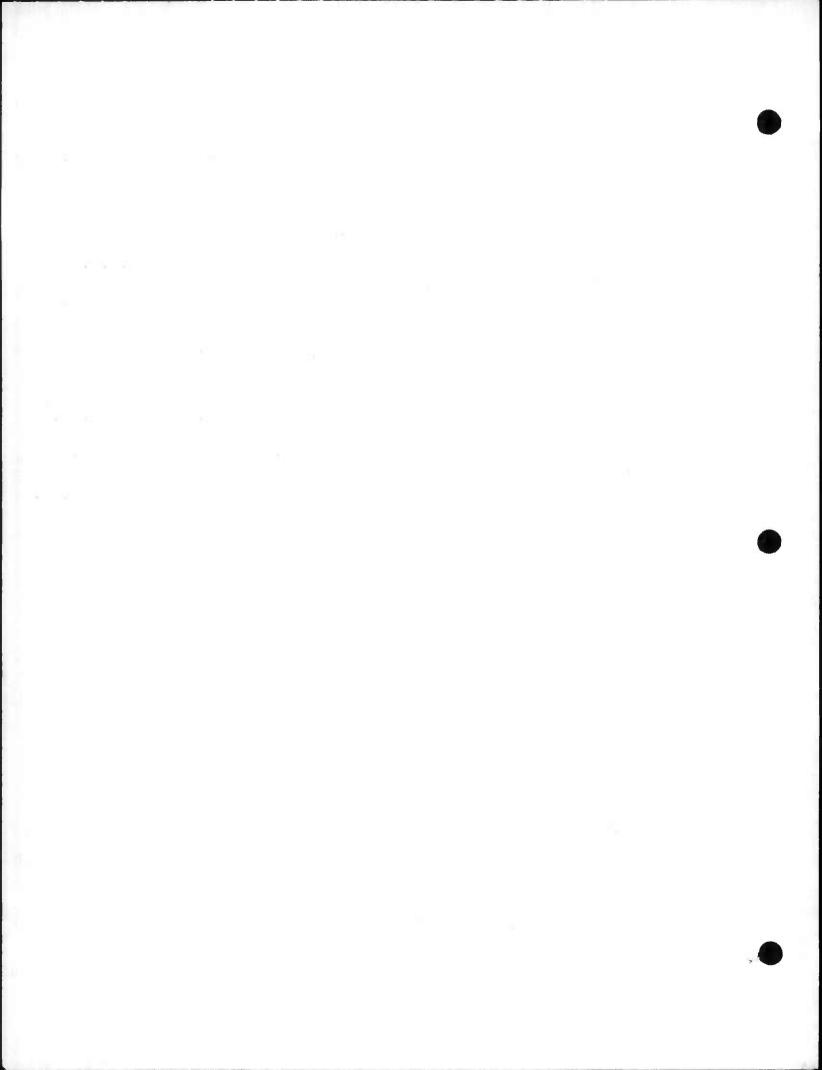
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

		AlliC	inded- 1	. cem	1 1 9	057	29/90 ,	WOIII	, eau	9!	5 (31296
	1 - FOR STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MENTA	REG. NO.	E		
i i	1. OECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH			3. TIME OF DEATH
	LARRY D.					5h	HANER		TEMBE		, 1995	1822 M
	4. SOCIAL SECURITY NUMBER 176-40-4041	5. SEX 1 🙀 M 2 🗌 F	6. AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH th, Day, Year) 31-194		8. BIRTHE Country	PLACE (State or Foreign PENN.
	9a. FACILITY NAME (If not institution, give str	reet and number)	- 47		9b, CITY.	TOWN 0	OR LOCATION OF D	DEATN 9c. COUNTY O			NTY OF OF	ATN .
DIRECTOR	PENINSULA REGIONA	AL MEDICA	L CENTE	R			SBURY				VICOM	
E C	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY
급	MD. WICO	MICO		S	ALIS	BUR	Y					LIMITS?
A A	10e. STREET AND NUMBER					-	. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	6890 LOIS AV	ENUE			21801						U.S	. A .
15	(11.)MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	WED	13. V	WAS DECI	ENDENT OF HISPA	NIC ORIGI	N7 (Specify Yea	or No—	14. RACE	- American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA	YES 2 N	0	If yes, specify Cuban, Mexican, Puerto Rice 1 YES 2 NO Specify:						Black, Specify	WHITE
G	15. DECEDENT'S EDUC	18a. DEC	CEDENT'S	USUAL OC	CUPATIO	ON .	16	b. KIND OF BUS	SINESS/IND	USTRY	WHILE	
COMPLETED	18. DECEDENT'S USUAL OCCUPATION 18e. DECEDENT'S USUAL OCCUPATION 18e. DECEDENT'S USUAL OCCUPATION 18e. KIND OF BUSINESS/INDUSTRY 18e. December of working 18e. December of											
4	12			LF :	EMPL	OYE	D		ROAD	CONS	STRU	CTION
ő	17. FATHER'S NAME (First, Middle, Lest)						16. MOTHER'S N.	AME (First,	Middle, Malden	Surname)		
BE (DEAN SHANER BETTY JANE MOTTER											
TO B	196. INFORMANT'S NAME (Type/Print) SALLY SHANER 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21801 1207 C, BRITTINGHAM ST., SALISBURY, MD.											RY-MD-
	20s. METNOD OF DISPOSITION		20b. PLACE A	ND DATE (
20s. METNOD OF DISPOSITION 1 General Sylicity Commence of CAMBRIDGE, MD a 20s. PLACE AND DATE OF DISPOSITION (Name of Campatery, Crematory of other clips of CAMBRIDGE, MD a 20s. METNOD OF DISPOSITION (Name of Campatery) 20s. PLACE AND DATE OF DISPOSITION (Name of Campatery) 20s. METNOD OF DISPOSITION (Name of Ca												
	Duald C	(Fores	nd		В	OUN	DS FUN	ERAI	. номе	. S/	ALTS	BURY, MD.
	23. PART i. Enter the diseases, or co	omplications that	caused the das	ath. Do r	ot anter	tha mod	de of dying, au	ch as car	diac or respi	ratory srr	est,	Approximata
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death											
	disease or condition resulting in death) - a a case Pickmonova Edema											
	Toolston, and the state of the	DUE TO (DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequantially list conditions,		Chron	nic	R	na	Fai	her				
일	if any, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF	7:	1		MILLIE TO				
CERTIFICATION	Cause, Entar UNDERLYING CAUSE (Disease or Injury		apa	18	5	Di	Spare					
붙	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQ	UENCE OI	ን:							
5	d.											
1 -	PART II. Other significant conditions	contributing to d	aath but not re	aulting	n tha uno	derlying	cause givan in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL	Chlanic	dotre	H	2002	fix				PERFOR	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	100								1 1 763 2	NO NO		OF DEATH?
2	DID TOBACCO USE CONTR	BUTE TO CAL	ISE OF DEAT	TH YE	SIN	ΙΩП	UNCERTAI	ΝП				1 YES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL				H (Check o		OTTOLKIA					
PHYSICIAN:	EXAMINER? 1 VES 2 NO	HOSPITAL:	ER/Outpetlant 3	□ DOA	OTHER		5 🗆 Realdence	6 □ Oth	ne (Specific)			
È	27. MANNER OF DEATN	28a. DATE OF II	JURY	28b. TIM	E OF	28c. INJL	JRY AT	7	SCRIBE HOW IF	NJURY OCC	URED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	, rear)	INJ	URY M	1 Y	RK7 ES 2 NO					
	3 Suicide 8 Could not be	ild not be 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Tweet Street.									oute Number,	
<u>Li</u>												
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC											
00	2 MEDICAL EXAMINER	: On the beels of axa	mination and/or in	vestigatio	n, in my op	inion, de	nath occured at the	time, date	a and place, and	d due to the	p cause(a)	and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1 01	//				29c. LICENSE NU			29d. DATE	SIGNED	Month, Day, Year)
0	Dento	ひ.		en	KO		0-2	00	50	1	//20	0/95
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLS	OF DEATH ATEM	070 /5	Christi						7	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pr

32 MEGISTBAR'S SIGNATURS

31. DATE FILED (Month, Day, Year) SEP 22 1995



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

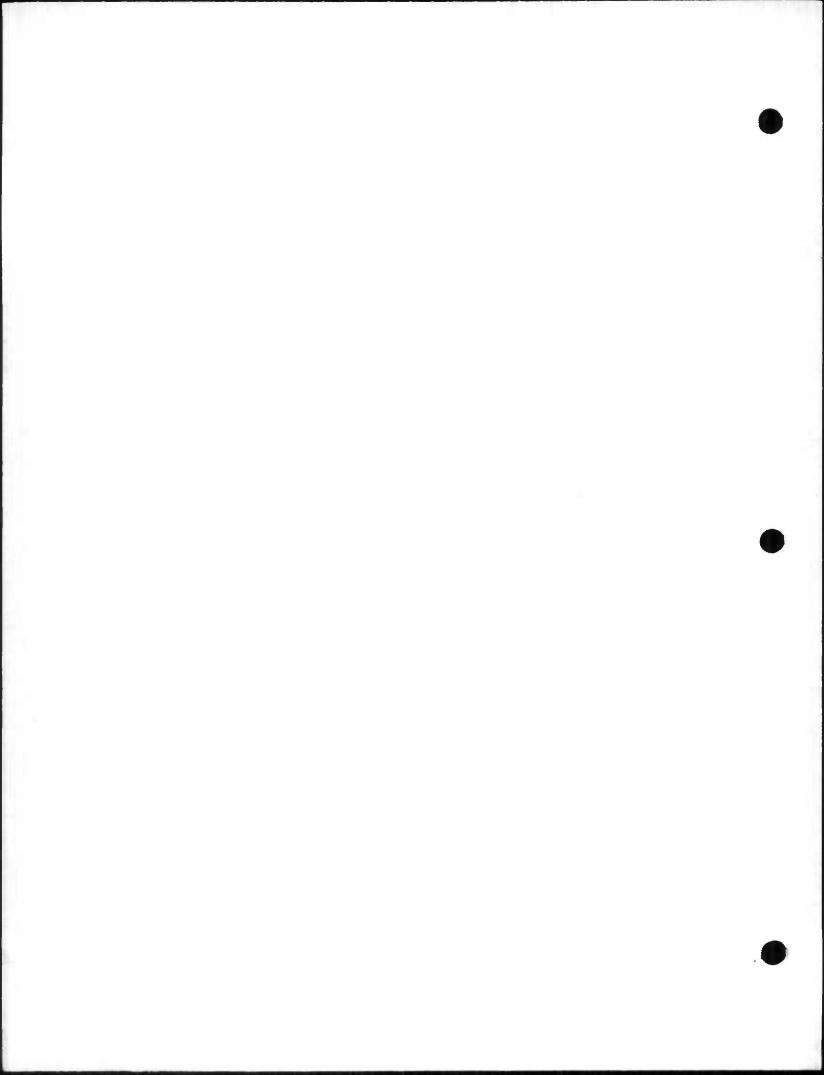
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			ICATE O	DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	DOROTHY	MARIE	SMU	LLEN			AY YEA				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In vrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Sept. 15		9:45 A M			
	213-14-7309	1 M 2 K F	7.0	MONTHS DAY		(Month, Day, Year)	E. BI	IRTHPLACE (State or Foreign puntry)			
			/9 YRS.			May 13, 1916		Maryland			
	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOW	N OR LOCATION OF DE	ATH	9c. COUNTY O	OF DEATH			
5	Salisbury NUrsi	ng & Rehab C	enter	Salisb	ury, Md.		Wicomi	.co			
	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNTY	Y	10c. CIT	Y, TOWN OR LO	CATION			10d, INSIDE CITY			
능	Maryland	Wicomico	F	ruitlan	d			LIMITS?			
	10e. STREET AND NUMBER							TXX YES 2 □ NO			
FUNERAL					101. ZIP CODE 2 1826			OF WHAT COUNTRY?			
9	Clyde Ave.				USA	A .					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS D	ECENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No.— 14. R	IACE — American Indian, Black, White, atc.			
-	1 Never Married 2 Married	FORCES? 1 YES		If yes,							
BY	3 Widowed 4 Divorced			1	ES 2 NO Specify	•	,	pedly: White			
	15. DECEDENT'S EDU		16a. DECEDENT'S	USUAL OCCUPA	TION	18h KIND OF BU	DINESC/INDISTE				
E	(Specify only highest grade		(Give kind of life. Do NOT u	of work done during most of working							
7	Elementary/Secondary (0-12) College (1-4 or 5+)										
E	Housewife										
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)							
BE (James Clay	White			Marth	a Emil	y Sn	nack			
	19a. INFORMANT'S NAME (Type/Print)	n, State, Zip Code,	1								
2	Samuel Smullen					Hebron, M					
	20a. METHOD OF DISPOSITION										
	1X Buriel 2 Cremeticin 3 🗆 Reme	oval from State Co	b. PLACE AND DATE	OF DISPOSITION	Name of	1	CATION — City o				
	4 Donution 5 Dother/(Specify)		metery, cremetory or o	orial Pa	rk	9/18 Sa	lisbury	, MD			
	21. BIOMATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	1 Hom	1/10//		Ho1	loway Fune	eral Home					
501 Snow Hill Rd., Salisbury, MD 21801											
	25 PART I. Enter the diseases, or o	complications that course	d the death. Do	not enter the n	node of dying, sucl	h as cardiec or respi	ratory arrest,	Approximata			
	MMEDIATE CAUSE (Final	List only one cause on	sach line.					interval Between			
	disease or condition	1 6	1000	. —		766	1	Onset and Death			
	resulting in death)	a. Marie	1737180	19700W	El-Bock	1 07 43	every	2/10m			
	disease or condition resulting in death) a. Acute ASPIRATION Episocky Reporting 2 1 storm DUE TO (OR AS A CONSEQUENCE OF): TO TROATMENT PYON ITING										
Z	Sequentially list conditions,	b					O				
Ĕ	If any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE O	F):							
2	CAUSE (Disease of Injury	(772)	obse								
Ē	CAUSE (Disease or Injury	c		F):							
⊢	that initiated events	DUE TO (OR AS	A CONSEQUENCE O								
1		DUE TO (OR AS	A CONSEQUENCE O	,				j			
CER	that initieted events resulting in death) LAST	d									
AL CERTIFICATION	that initieted events resulting in death) LAST	d			ing cause given in	Part L. 24s. WAS AN	AUTOPSY :	24b. WERE AUTOPSY FINDINGS			
	that initiated events resulting in death) LAST PART II. Other aignificant condition	d	but not resulting	In the underly		PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPETITION OF TO AUTO-			
	that initiated events resulting in death) LAST PART II. Other aignificant condition	d	but not resulting	In the underly	ing cause given in.	DEDEOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL CER	PART II. Other aignificant condition	d	out not resulting	in the underly	Ascasy	PERFOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	that initiated events resulting in death) LAST PART II. Other aignificant condition	d	out not resulting	in the underly	Ascasy	PERFOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDICAL	PART II. Other aignificant condition LAC DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	d	out not resulting	in the underly	FORTHY	PERFOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	PART II. Other aignificant condition HF, ASC DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE C	DE DEATH YE	in the underly	ASZAZYY UNCERTAIN	PERFOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
SICIAN: MEDICAL	PART II. Other aignificant condition HF, ASC DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	RIBUTE TO CAUSE C	DEFINITION OF DEATH YE	in the underly S NO IN (Check only on OTHER: 45 Nursing He	UNCERTAIN Ome 5 Rasidence	PERFORM 1 YES 2	MEO?	ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
MEDICAL	PART II. Other algorificant condition HF DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	RIBUTE TO CAUSE C	DF DEATH YE 28. PLACE OF DEA 28b. TIM	In the underly S NO If (Check only on OTHER: 4 Nursing H E OF 28c. II	ASZAZYY UNCERTAIN	PERFOR	MEO?	ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN: MEDICAL	PART II. Other algnificant condition HR. DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 28s. DATE OF INJURY	DF DEATH YE 28. PLACE OF DEA 28b. TIM	In the underly S NO If (Check only on OTHER: Mursing He EURY S C II	UNCERTAIN O) Ome 5 □ Rasidence NJURY AT	PERFORM 1 YES 2	MEO?	ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
BY PHYSICIAN: MEDICAL	PART II. Other algnificant condition H. J. J. J. J. J. J. J. J. J. J. J. J. J.	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year)	DEATH YE 28. PLACE OF DEATH Petient 3 DOA 28b. TIM INJ Y — At home, farm,	In the underly S NO If (Check only on OTHER: Nursing He E OF 28c. II URY M 1	UNCERTAIN by by come 5 Rasidence NJURY AT VORK? YES 2 NO	PERFORM 1 YES 2 1 YES 2 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street a	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
D BY PHYSICIAN: MEDICAL	PART II. Other algnificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Morth, Day, Year)	DEATH YE 28. PLACE OF DEATH Petient 3 DOA 28b. TIM INJ Y — At home, farm,	In the underly S NO If (Check only on OTHER: Nursing He E OF 28c. II URY M 1	UNCERTAIN by by come 5 Rasidence NJURY AT VORK? YES 2 NO	PERFORM 1 YES 2	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
D BY PHYSICIAN: MEDICAL	PART II. Other aignificant condition HF. ASC DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	RIBUTE TO CAUSE C MOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	DE DEATH YE 28. PLACE OF DEAT Petient 3 DOA 28b. TIM INJ Y — At home, farm, 6	In the underly S NO ITH (Check only on OTHER: 4 Nursing He E OF URRY M 1 URRY Iterat, fectory, of	UNCERTAIN e) DOME 5 Residence NURY AT VORK? YES 2 NO	PERFORM 1 YES 2 1 YES 2 Other (Specify) 26d. DESCRIBE HOW II City or Town, State)	NONJURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
D BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other aignificant condition HF. DID TOBACCO USE CONTINE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE C MOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe	DEFINITION OF DEATH YE 28. PLACE OF DEATH 28b. TIM 27 — At home, farm, or city)	In the underly SS NO ITH (Check only on OTHER: 4 Nursing He E OF URY M 1 URY M 1 the time, de	UNCERTAIN E) Ome 5 Residence NURY AT VORK7 YES 2 NO Residence No Resi	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street a City or Town, State)	NJURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
D BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other aignificant condition HF. DID TOBACCO USE CONTINE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE C MOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	DEFINITION OF DEATH YE 28. PLACE OF DEATH 28b. TIM 27 — At home, farm, or city)	In the underly SS NO ITH (Check only on OTHER: 4 Nursing He E OF URY M 1 URY M 1 the time, de	UNCERTAIN E) Ome 5 Residence NURY AT VORK7 YES 2 NO Residence No Resi	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street a City or Town, State)	NJURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
COMPLETED BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other aignificant condition HF. DID TOBACCO USE CONTINE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26s. PLACE OF INJURY building, etc. (Spe	DEFINITION OF DEATH YE 28. PLACE OF DEATH 28b. TIM 27 — At home, farm, or city)	In the underly SS NO ITH (Check only on OTHER: 4 Nursing He E OF URY M 1 URY M 1 the time, de	UNCERTAIN e) ome 5 Residence NJURY AT VORK? YES 2 NO lice te and place, and due death occured at the	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street of City or Town, State) 10 the cause(a) and mer time, date and place, an	NJURY OCCURED and Number or Run oner as stated. d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO rel Route Number,			
D BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other algnificant condition H. J. J. J. J. J. J. J. J. J. J. J. J. J.	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe	DEFINITION OF DEATH YE 28. PLACE OF DEATH 28b. TIM 27 — At home, farm, or city)	In the underly SS NO ITH (Check only on OTHER: 4 Nursing He E OF URY M 1 URY M 1 the time, de	UNCERTAIN E) WHO S Residence NJURY AT VORK? YES 2 NO Ites Ite and place, and dua death occured at the 29c. LICENSE NUM	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street and City or Town, State) 10 the cause(a) and meritime, date and place, and IBER	NJURY OCCURED and Number or Rur aner as stated, d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Tel Route Number, Se(s) and manner as stated. MED (Month, Day, Year)			
BE COMPLETED BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other aignificant condition HF. ASC DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE C MOSPITAL: 1 Inpatient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	Dut not resulting CHPCO DF DEATH YE 28. PLACE OF DEATH Pattern 3 DOA 28b. TIM INJ Y—At home, farm, or on and/or investigation and/or investigation	In the underly S NO IN (Check only on OTHER: 4 Nursing He E OF URY M 1 Ury Intreet, fectory, of	UNCERTAIN e) ome 5 Residence NJURY AT VORK? YES 2 NO lice te and place, and due death occured at the	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street and City or Town, State) 10 the cause(a) and meritime, date and place, and IBER	NJURY OCCURED and Number or Rur aner as stated, d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO rel Route Number,			
E COMPLETED BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other algnificant condition H. J. J. J. J. J. J. J. J. J. J. J. J. J.	RIBUTE TO CAUSE C MOSPITAL: 1 Inpatient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	Dut not resulting CHPCO DF DEATH YE 28. PLACE OF DEATH Pattern 3 DOA 28b. TIM INJ Y—At home, farm, or on and/or investigation and/or investigation	In the underly S NO IN (Check only on OTHER: 4 Nursing He E OF URY M 1 Ury Intreet, fectory, of	UNCERTAIN E) WHO S Residence NJURY AT VORK? YES 2 NO Ites Ite and place, and dua death occured at the 29c. LICENSE NUM	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street and City or Town, State) 10 the cause(a) and meritime, date and place, and IBER	NJURY OCCURED and Number or Rur aner as stated, d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Tel Route Number, Se(s) and manner as stated. MED (Month, Day, Year)			
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TO BE COMPLETED BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other aignificant condition H. J. J. J. J. J. J. J. J. J. J. J. J. J.	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe CIAN: To the best of my know R: On the bests of axemination COMPLETED CAUSE OF DE	Dut not resulting CHOLD DF DEATH YE 28. PLACE OF DEA 28b. TIM 18b. Y — At home, farm, or or livestigation and/or investigation EATH (ITEM 27) (Type. THWAY DR	in the underly SS NO NO TH (Check only on OTHER: 4 Nursing He E OF URRY M 1 URY M 1 the time, de on, in my opinion, Print) SALISE	UNCERTAIN One 5 Rasidence NJURY AT VORK7 YES 2 NO Hica As and place, and dua death occured at the 29c. LICENSE NUM D—39813	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street and City or Town, State) 10 the cause(a) and meritime, date and place, and IBER	NJURY OCCURED and Number or Rur aner as stated, d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Tel Route Number, Se(s) and manner as stated. MED (Month, Day, Year)			
TO BE COMPLETED BY PHYSICIAN: MEDICAL	That initieted events resulting in death) LAST PART II. Other algnificant condition H	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe CIAN: To the best of my know R: On the bests of axemination COMPLETED CAUSE OF DE	Dut not resulting CHOLD DF DEATH YE 28. PLACE OF DEA 28b. TIM 18b. Y — At home, farm, or or livestigation and/or investigation EATH (ITEM 27) (Type. THWAY DR	in the underly SS NO NO TH (Check only on OTHER: 4 Nursing He E OF URY M 1 URY M 1 Intreet, fectory, of od at the time, da n, in my opinion.	UNCERTAIN One 5 Rasidence NJURY AT VORK7 YES 2 NO Hica As and place, and dua death occured at the 29c. LICENSE NUM D—39813	PERFORM 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW II 26f. LOCATION (Street and City or Town, State) 10 the cause(a) and meritime, date and place, and IBER	NJURY OCCURED and Number or Rur aner as stated, d due to the cause	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Tel Route Number, Se(s) and manner as stated. MED (Month, Day, Year)			



BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

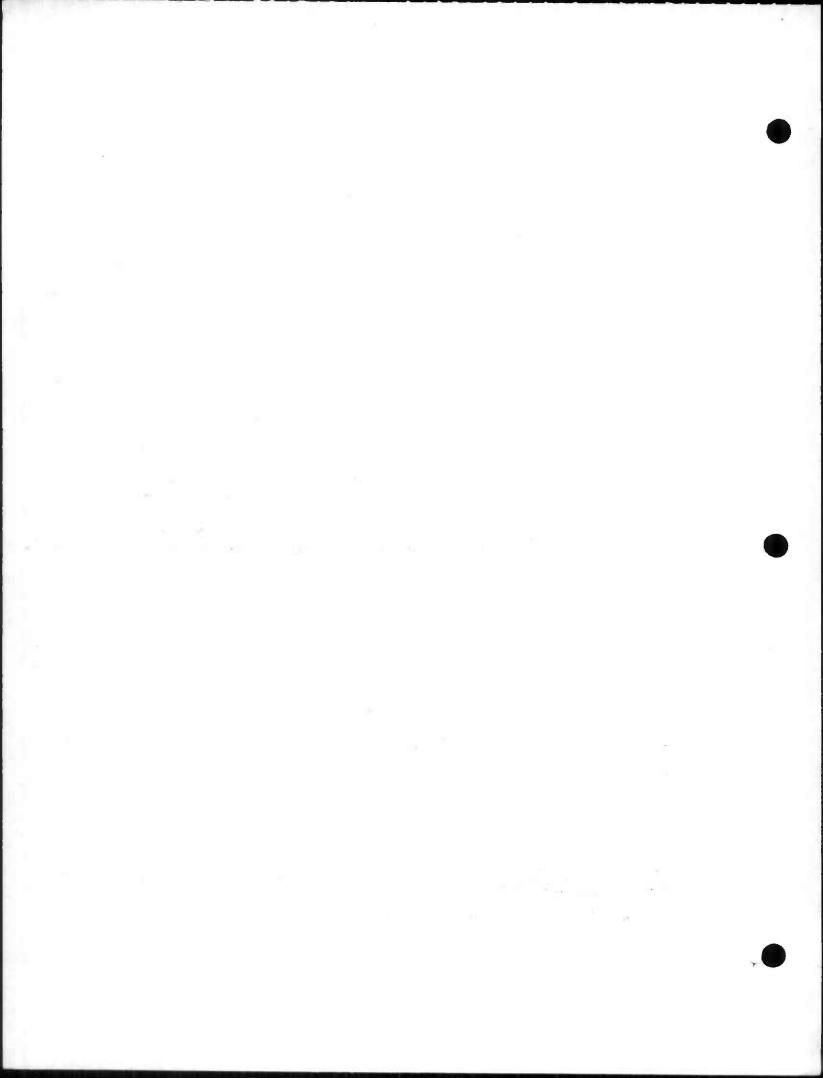
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, at hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

WHODRTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		C	ERTIF	ICATE	OF	DEATH	REG	NO.				
1	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEA	TH DAY	YE		TIME OF DEATH	
	Albert	Ferdi	nand		SET	TER		Sept.	30	199	-	8:12 n	М
н	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. le	st birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIGT	ы	0.5	HRTHPLA	CE (State or Foreign	
	219-07-5837	1 € M 2 □ F	78	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, Day, Ye February	12,	1917 i	lew	York	
	So. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	, TOWN C	R LOCATION OF DE			c. COUNTY	-		
œ	Memorial Heggital			Easton					Talbot				
은	Memorial Hospital	-				Just	J11		raibot				
Ĕ I	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION				10-	I, INSIDE CITY LIMITS?	
DIRECTOR	Maryland Card	oline		T	Dento	าท					1 [YES 2 TONO	
	10e. STREET AND NUMBER	7.1110					. ZIP CODE		1	0g. CITIZEN	OF WHA	COUNTRY?	
FUNERAL	8564 Harmony Road	1					21629			U.S.	.A.		
Ξ	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Spec	fy Yes or	No- 14.	RACE -	American Indian,	
	1 Never Married 2 Married	FORCES? 1	YES 2	NO		It yes, sp	ocify Cuban, Maxica 2 NO Specify	n, Puerto Rican, el	C.)		Black, W Specify:	hita, atc.	
B	3 Widowed 4 Divorced	WW II					a lite opassing					sian	
	15. OECEDENT'S EDUC	CATION		ECEDENT'S				16b. KIND 0	F BUSIN	ESS/INDUST			
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	- Bit	e. Do NOT us	work done se retired.)	aunng mo	st of working						
4	4			Carpe	ente	r		Cons	tru	ction			
COMPL	17. FATHER'S NAME (First, Middle, Lest)						18. MOTHER'S NA	ME (First, Middle, A	aiden Sur	name)			
Michael 13006 Coller Hmma Mil/Gentaler													
BE	19a. INFORMANT'S NAME (Type/Print)	-		9b. MAILING	ADDRES	S (Street I	nd Number or Rural I			-	(a)		
임	Helen M. Seiler			8564	Harr	nonv	Road, D	enton, N	fary:	Land :	2162	9	
1	20a. METHOD OF DISPOSITION		20h PLACE								_		
20a METHOD OF DISPOSITION 1 X Surfal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cametery Competery or other place) Maryland Fastem Shore Veterans 10/1 Beulah, Maryland 220. LOCATION — City or Town, State 220. LOCATION — City or Town, State 220. LOCATION — City or Town, State 220. LOCATION — City or Town, State 220. LOCATION — City or Town, State 220. LOCATION — City or Town, State 221. NAME AND ADDRESS OF FACILITY													
- 1	Moore Funeral Home, P.A.												
	PO Drawer B, Denton, Maryland 21629												
	23. PARIF I. Enter the diseases, or c shock, or heart in lure.				not enter	r the mo	de of dying, auc	h aa cardiac or	respirat	ory srrest		Approximata Interval Batwe	
	iMMEDIATE CAUSE (Finel	List only one ceu	se on eech iii			-1			-	~		Onset and De	
	disease or condition resulting in death)	Arter	nerla	200	(Las	diovas	dular	D	200-	1	Year	4
	resorting in deatily	DUE TO	OR AS A CONS									,	
z		b.											
은	Sequentially list conditions, if any, leeding to immediate	DUE TO	OR AS A CONS	EOUENCE O	F):								
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	C											
CERTIFICATION	that initiated events	DUE TO	OR AS A CONS	EQUENCE O	F):								
ᇤᅵ	resulting in death) LAST	d											
	PART II. Other significant condition	e contribution to	death but not	regulting	In the Is	nderluln	a cause alven in	Part i 24a W	AS AN AU	mosev	245 W	RE AUTOPSY FINOING	GS.
ΧI	PART II. Other algunicality condition	e contributing to	death pat not	resuming	III THE G	ildertylli	y cause given in		ERFORME		AV	AILABLE PRIOR TO	
ă	l ————							1 🗆 '	ES 2	ONO		DEATH?	
뿔											1	YES 2 NO	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT	RIBUTE TO CA					UNCERTAIL	N D					
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL/	ACE OF DEA	OTHE								
Š	1 YES 2 NO	1 Inpatient 2	ER/Outpatient	3 NOOA			ne 5 🗆 Rasidence	8 Other (Speci	y)				
E	27. MANNER OF DEATH	28a, DATE OF (Month, Di	INJURY ay, Year)	28b. TIR	AE OF JURY	28c. IN.	JURY AT ORK?	28d. DESCRIBE	HOW INJ	URY OCCUR	ED		
ΒY	1 Natural 5 Pending 2 Accident Investigation				M		YES 2 NO						
0	3 Suicide 8 Could not be		F INJURY — At I atc. (Specify)	homa, farm,	atreet, fac	ctory, offic	:0	281, LOCATION (City or Town		Number or I	Rural Rout	e Number,	
	4 Homicide detarmined								0,0,0				
۳	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge.	death occur	red at the	time, data	and place, and due	to the cause(a) a	nd manne	r as stated.			
COMPLETE	(Check only one) 2 MEDICAL EXAMINE										use(a) a	nd manner as stated	l.
8													
B	290, SIGNAPORE AND TITLE OF SERLIFIE	3					29c. LICENSE NUI		13	DATE SI	Z.	onth, Day, Year)	
6			DE OF 251	F14 CT -	- 0.1.1		D24	767		- 7	1 20	175	
	30, NAME AND ADDRESS OF PERSON WH												
	L. Thomas Divil:				, Eas	ston	, Maryla	nd 21601					
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE										
	OCT - 4 '95	Sicha Da	Hidson B	note of									
	OCT - 4 °95 Gicha Jandon Rondine												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

								50	J	129	9
	1 - FOR STATE REGISTRAR	TATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND DEATH	MENTAL	HYGIEN REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, Last)			- 		2. DATE O	F DEATH	W	YEAR	3. TIME OF D	EATH
			efer				er 2, 1		TEAN	3:20	P M
			n yrs. last birtnday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE O	F BIRTH Day, Year)		8. BIRTI Count	HPLACE (State o	r Foreign
	T34-T4-3034	M 2 🔀 F	92 YRS.	MONTHS DATE	HOURS MIN.					rmany	
_	9a. FACILITY NAME (If not institution, give street a			96. CITY, TOWN (R LOCATION OF D						
6	Caroline Nursing Ho	me		Dente	on	Caro1			line		
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CIT	Y, TOWN OR LOCAT							
E	3/2		100	,				10d, INSIDE C			
	Maryland Caroli 100, STREET AND NUMBER	ne		enton 1 101	10g. CITIZEN OF WI			1 YES 2			
FUNERAL	26144 Sannatt Band			"	U.S.A.				· ·		
N	26144 Sennett Road 11. MARITAL STATUS 12.	WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	NIC ORIGIN?	(Specify Yea				ndlen	
	1 Never Married 2 Married	FORCES? 1 YES	2 2 NO		en, Puarto Ri		0.110	Blac	E — American I k, White, atc.	reason,	
ВУ	3X Widowed 4 Divorced	140, 0112 1011 011 011	., 20	1 1 10	· y			-	casian		
EU	15. DECEDENT'S EDUCATIO (Specify only highest grade comp		16a. DECEOENT'S	USUAL OCCUPATION	ON of working	16b. I	CIND OF BUS	SINESS/IN	DUSTRY		
<u> </u>		llege (1-4 or 5+)	life. Do NOT us	e retired.)							
M	12		Home	maker			Hor	ne			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-		ME (First, Mi	ddle, Malden	Surname)					
BE	Waigand Ste	nglein			В	arbar	a Wol	f			
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	George Schaefer 26144 Sennett Road, Denton, Maryland 2163										^
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)										
	4 Donation 5 Other Specify)	Re	surrecti	on Ceme			6 Pis	catar	way,	New Je	ersey
	21 SIGNATURE OF FUNERAL SERVICE UCENSE	" }	2		D ADORESS OF FA		- D	2			
	KowckeD	1 1 11	sone		e Funera rawer B,				and '	21629	
	23. PART I. Inter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardisc or respiratory arreat, shock, or heart failure. List only one cause on each line. Approximate interval Batwean Onset and Death disease or condition Previous Complex										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
	PART II. Other algnificant conditions co	ntributing to death bu	it not resulting i	n the underlying	cause given in	Part I.	24a. WAS AN		24b	WERE AUTOPS	
PHYSICIAN: MEDICAL	IDDM, DID						PERFOR	100		COMPLETION C	
	,								- 1	OF DEATH?	NO
5	DID TOBACCO USE CONTRIBU	JTE TO CAUSE OF	F DEATH YE	s □ NO 🗵	UNCERTAI	N \square					
A	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEAT							-	
3		SPITAL: Inpetient 2 - ER/Outpi	itlent 3 DOA	OTHER:	5 🗆 Residence	6 Other	Speciful				
Ē	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIMI	E OF 28c. INJ	JRY AT		RIBE HOW II	NJURY OC	CURED		
	1 Natural 5 Pending	(Month, Day, Year)	INJ		RK? ES 2 NO	12.41100					
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY	— At home, farm, s	treet, factory, office		28f. LOCAT	ION (Street a	nd Number	r or Rural I	Poute Number,	
ш	4 Homicide determined	building, atc. (Speci	Ty)			City or	Town, State)				
COMPLE	29a. CERTIFIER DESCRIPTION DAYS CLAN-	To the heat of my knowle	des doub seems	d at the time day							
Ē	22. CERTIFFUNG PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) are									and manner a	n etetad
	29b. SIGNATURE AND TITLE OF CENTIFIER										
N P	The state of the s				29c. LICENSE NUI	9U		29d. OAT	E SIGNED	(Month, Day, Ye	ac)
2	30. NAME AND ADDRESS OF PERSON WHO COL	MPI ETED CAUSE OF DEA	TH (ITEM 27) /3	Print)	0000	7		- 16	2/4	117	
	Robinson L. l	appin N	\$ 9		rket	5+,	Dens	ton	M	2.210	29
	31. DATE FILED (Month, Day, Year) $0CT - 4 '95$	32 REGISTRAN'S SIGNA									

i, k e

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the forms after death. Page 6 may be retained by the hospital or attending physician.

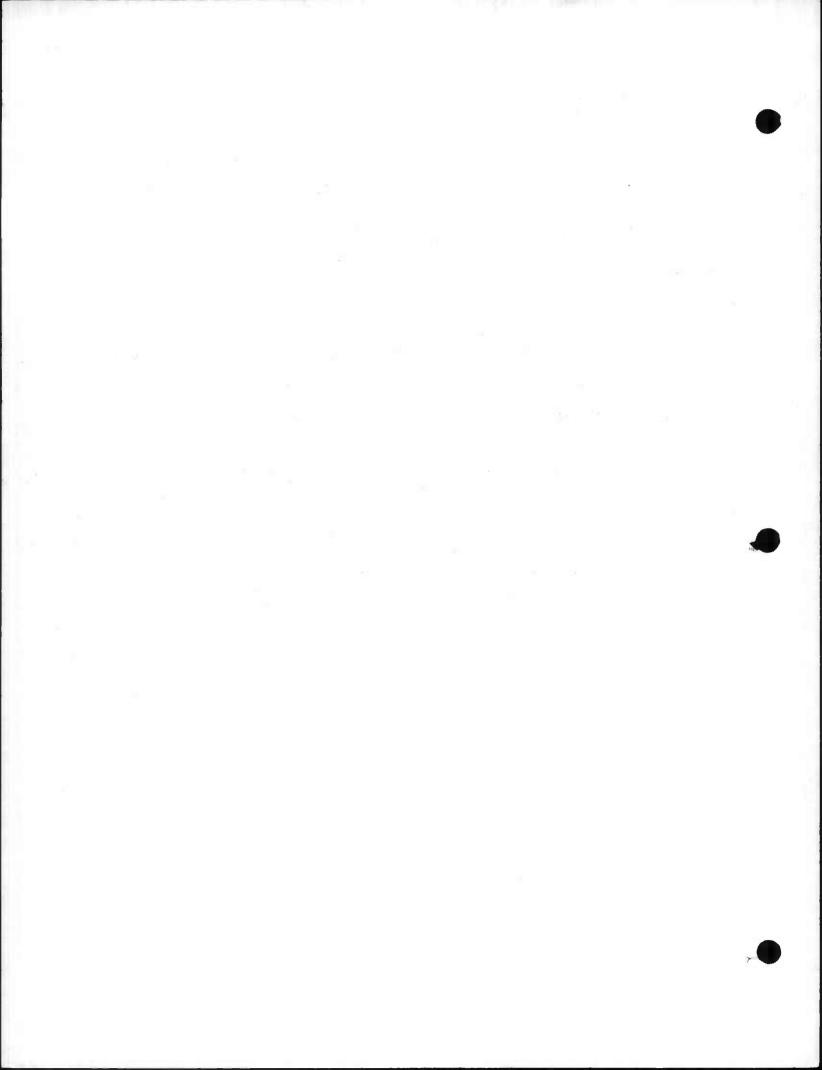
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	t, Middle, Last)							7 6	2. DATE OF	DEATN			3. TIME OF DEATH
	PAMELA	Jea	n	SHOR	ES					Sest	29	The 1	995	6:00 PM
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTN	-	8. BIRTI	IPLACE (State or Foreign
	220-60-750	7	1 🗆 M 2 📈 F	42	YRS.	MONTHS	DAYS	HOURS	MIN.	Aug.	Day, Year)	953	Count	ryland
	9a. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CITY,	TOWN	OR LOCATE	ON OF DE		., 1		NTY OF D	2
OR	University	Hospi	tal			Ba	11ti	Lmore				C	ity	
5	RESIDENCE OF DEC	10b. COUNTY									<u>.</u>			
DIRECTOR						Y, TOWN O								10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER		oline		G	reens	_							1 TES ZANO
FUNERAL	12159 Green		D = - 1				1	of, ZIP COD				10g. CITIZEN OF WHAT COUNTRY?		
ᄬ	11. MARITAL STATUS	isboro	12. WAS DECEDEN				\perp		639		U.S.A.			,
	1 Never Married 2 🛣	Married	FORCES? 1	YES 2	Z-NO	HO If yes, specify Cuban, Maxican, Puerto Rican, etc.)					or No-	14. RACE — American Indian, Black, White, atc.		
B	3 Widowed 4 Divo	prood	IF YES, GIVE Y	MAR OR DATES		1 YES ZYNO Specify: Specify:						"y: White		
ᇜᅧ		EDENT'S EDU		16a.	OECEDENT'S	ENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY					WIIICC			
COMPLETED	Elementary/Secondary (6	y highest grade 0-12)	College (1-4 or 5	+)	(Give kind of life, Do NOT u	kind of work done during most of working NOT use retired.)						-0411.77	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
린	12				office	ice manager					1 Est	tate	Comr	anv
ő	17. FATHER'S NAME (First, M	fiddle, Last)				18. MOTNER'S NAME (First, Middle, i							COM	, all
BE	August Hell	Lman				Florence Elton Hellman								
2	19a. INFORMANT'S NAME (7	19b, MAILING	LING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
F	James R. Shores					59 Gr	een	sbord	Roa	ad Gr	eensl	oro,	Mar	yland 21639
	20s. METNOD OF DISPOSITION 1 1 Burlal 2 Cremation 3 Removal from State				E AND DATE	12159 Greensboro Road Greensboro, M DDATEOFDISPOSITION (Nome of OATE 20c. LOCATION — City of								
	4 Donation 5 Other							oro Cemetery 10/3 Greensboro, Ma						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
Fleegle-Helfenbein Funeral Hom P.O. Box 160 Greensboro Maryla									lome					
	23. PART T. Enter the d	Iseasea, or o	omplications the	t caused the	death. Do	not enter	the m	ode of dyi	Ing, such	reens	c or reapi	Mary ratory an	Land	21639 Approximate
shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final												HEESE .	Interval Between Onset and Death	
	disease or condition													
- 1	oue to (or as a consequence of):													
z	DISSEMINATED INTRAVASCULAR COACULATION 10 days													
임	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or Inju		ACUTE		To to coo I I to Looke wan.								2 years.	
=	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONS	SEQUENCE O	F):								0
H	reading in death) LAS		1											
- 11	PART II. Other algnifice	ent condition	a contributing to	death but no	t reaulting	in the un	derivir	ng cause o	alven in I	Pert I. 24	Ia. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
3			_								PERFOR	MED?	"	AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDI										— ¹	YES 2	NO		OF GEATH?
2	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF DE	ΔTH V	:S 🗆 N	ا <u> ۱</u>	ZIINIC	ERTAIN					1 TYES 2 NO
SICIAN	25. WAS CASE REFERRED TO				ACE OF OEA				-LIVIAII)	, _				
	EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER 4 Num		ma 5 🗆 Ba	eldance (6 Other (S	Daniful.			
È	27. MANNER OF DEATN		28a. DATE OF	INJURY	28b. TIM	E OF	28c. IN	JURY AT	SUPPLIES (28d. OEŞCR		JURY OC	CUREO	
> II		Pending Investigation	(Month, D	ray, Year)	INJ	M	_	ORK? YES 2	NO					
	2 0 0 1111	Could not be	28a. PLACE O	F INJURY At	home, term,	streat, tecto	ory, offi	Ca	_			nd Number	or Runal F	Toute Number,
EIED		determined	bunding,	atc. (Specify)						City or	Town, State)			
ן בָּ	29a. CERTIFIER CERT	IFYING PHYSIC	CIAN: To the best of	my knowledge.	death occurs	nd at the tir	me det	e and place	and due t	to the source	(a) and man			
OMPL) and manner as stated.
ا د	29b. SIGNATURE/AND TITLE													
	Staro	OF OLITIFIER	MD						NSE NUM	- 0		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CALL	SE OF DEATH (TEM 273 (500a	Print)		D	469	0.10		- 3	CP1.	29# 1995
	CLARENCE	SARKO	PEE - H	Seo.	MMC	-								
	31. DATE PRESTMONTH, Day,	O.L	32: REGISTRA	H'S SIGNATURE					_					
	001 - 5	33	dunas	widson-1	jandell	•								



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	s certificate has been signed by the attending physician and completely filled in by the		MPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requ	TO THE FUNERAL DIRECTOR: After this certificate has been	be filed within 72 hours after death with the State Dept. of I	IMPORTANT: If Item 28 is marked, or Item 23 sho

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	1 . STATE STATE OF MANTILAND / DEPARTMENT OF HEALTH AND MENTAL HTGIENE									
1. DECEDENT'S NAME (First, Middle, Li	sst)			2. DATE OF DEATH	3. TIME OF DEATH					
HARVEY D	ORSEY SC	HEETZ		SEPT. 29,	1995 1938 P M					
4. SOCIAL SECURITY NUMBER		1.7	UNDER 1 YEAR IF UNDER 24 HRS, ITHS DAYS HOURS MIN.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign					
218-50-2950	1X M 2 🗆 F	1110.		Aug 27, 194						
90. FACILITY NAME (If not institution, g			CITY, TOWN OR LOCATION OF D	EATH 94	c. COUNTY OF DEATH					
FREDERICK MEM		TAL	FREDERICK		FREDERICK					
10a. STATE 10b. COL			OWN OR LOCATION		10d. INSIDE CITY LIMITS?					
	Frederick	Fr	ederick		1 X YES 2 NO					
100. STREET AND NUMBER 489 East Church	h Stroot		101. ZIP CODE 21.70		U.S.A.					
11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECENDENT OF HISPA							
1X Never Married 2 Married	FORCES? 1 YES	2 X NO	II yes, specify Cuban, Mexico	in, Puerto Rican, etc.)	Bleck, White, atc.					
3 Widowed 4 Divorced				1 □ VES 2 🕱 NO Specify: Specify: White						
15. DECEDENT'S (Specify only highest g	EDUCATION (rade completed)	16a. DECEDENT'S USL (Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUSINE	ESS/INDUSTRY					
Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance- Water Plant City Government										
17. FATHER'S NAME (First, Middle, Last)	110341100110		AME (First, Middle, Meiden Surr						
Dorsey		SCHEETZ	France		COLD A STATE OF					
19a. INFORMANT'S NAME (Type/Print)			DRESS (Street and Number or Rural							
William H. Sch	eetz	206 Eas	st Fifth Street	, Frederick	, Maryland 21701					
20e. METHOD OF DISPOSITION 1 [XBuriel 2] Cremetion 3] 1	Removel from State 20	b. PLACEAND DATE OF D	ISPOSITION (Name of	DATE 20c. LOCAT	ION — City or Town, Stata					
4 Donation 6 Other (Specify)		esthaven M	em Gar Oct 4,		erick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home										
23. PART I. Enter the displaces,	on Killern	✓ MOO706	106 E Church							
iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Atevo	each line.	Cardisvage	^	interval Batween					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	A CONSEQUENCE OF):								
PART II. Other significant cond	itions contributing to death	but not resulting in t	he underlying cause given in							
Servine	disorder			PERFORME 1 YES 2	NO COMPLETION OF CAUSE OF DEATH?					
DID TOBACCO USE CO	NTRIBUTE TO CAUSE (OF DEATH YES	□ NO □ UNCERTAI	NX	1 VES 2 NO					
25. WAS CASE REFERRED TO MEDICA	AL	26. PLACE OF DEATH	Check only one)							
1 X YES 2 NO	HOSPITAL: 1 □ Inpetient XIXER/Out		THER: Nursing Home 5 Residence	6 Other (Specify)						
27. MANNER OF DEATH	28a, DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 28c. INJURY AT WORK?	28d. DEŞCRIBE HOW INJU	JRY OCCURED					
Netural 5 Pending Investiget			M 1 YES 2 NO							
3 Suicide 8 Could not 4 Homicide determine	t be building, etc. (So	Y — At home, ferm, streed ecify)	st, factory, offica	28f. LOCATION (Street and City or Town, State)	Number or Rural Route Number,					
29a. CERTIFIER 1 CERTIFYINO P	'HYSICIAN: To the best of my kno	wledge, death occurred a	t the time, data and place, and du	s fo the cause(s) and manner	r as stated,					
MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner se stated.										
MATURE AND TITLE OF CERT	THE Caley	MO	O.C.M		DOCT. 1, 1995					
30. NAME AND ADDRESS OF PERSON	1 0	EATH (ITEM 27) (Type, Pri	*							
JUA LON L	UCKE, 100	111 Penn	Street, Bal	timore, Ma	aryland 21201					
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE								
OCT 0 2 19	95 Juli David	sor Rochelle								

Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per
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BE

2

TIFLE OF CERTIFIER

William

SEP2 8 1995

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. DEGISTRAR'S SIGNATURES

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tranklin

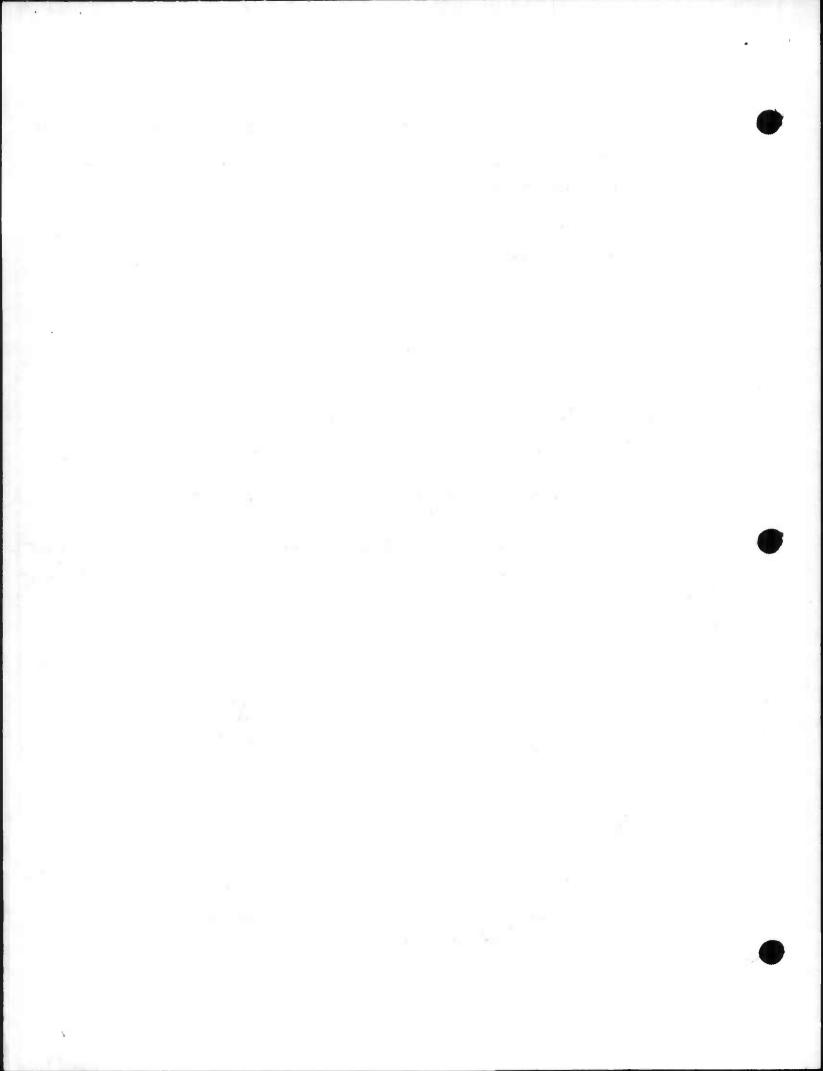
31302 ITEM: 7. PER F.H. FILM G-730 12/4/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 00 ISABELLE KEEFER THOMAS September 26 4 SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yeer) 1926 BIRTNPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 215-22-5504 69 HOURS 1 M 2 V AUG. 28 1906 Maryland Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY Maryland Dorchester Taylors Island 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4276 Bayshore Drive 21669 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If was specify Cuben, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indien, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rica

1 YES 2 X NO Specify: 1 Never Married 2XX Merried BY Specify: 3 Widowed 4 Divorced white 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (9-12) College (1-4 or 5+) homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Charles Edward Sears Sarah Violet Horseman B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Stanley G. Thomas 4276 Bayshore Drive, Taylors Island MD 21669 8 20e. METHOD OF DISPOSITION
1 Duriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE ISOE I ametery, crematory or other place) Br<u>ick Churchyard</u> 4 Donation 5 Other (Specify) 9/28 Taylors Island Md 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory strest, Approximate shock, or hasrt failure. List only one cause on each line. Interval Batw IMMEDIATE CAUSE (Final Onset and Death disease or condition Metastatic iuna resulting in death) rear OUE TO (OR AS A CONSEQUENCE OF): cemonia CERTIFICATION Sequentially list conditions, OUF TO JOB AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other aignificent conditions contributing to daeth but not resulting in the undarlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 24e. WAS AN AUTOPSY PHYSICIAN: MEDICAL 1 - YES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO м BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atraet, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the els of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and menner as stated.

29c. LICENSE NUMBER

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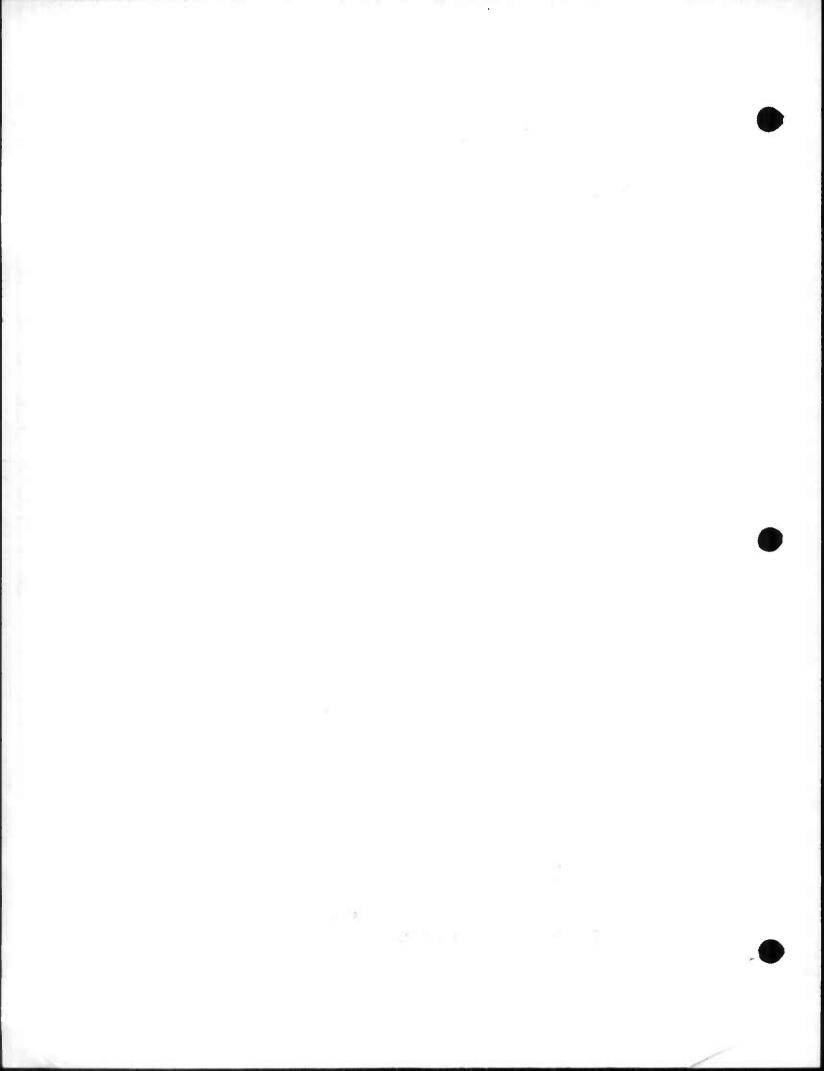
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	3 should		
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	Pages		
VYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1, 2, 3 shr	removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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certi	guipe	with the State Dept. of Health and Mental Hygiene prior to burial, cremation	r oth
death	afte	ental	٦, ٥
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NOING PHYS	er this	th wit	arke
NDIN	R. Afte	r deal	Is m
ALLE	HE FUNERAL DIRECTOR: After	be filed within 72 hours after death v	n 28
L OR	L DIR	hour	iten
SPITA	NERA	hin 72	H.
2	IE FU	DIM DE	HTA
2	12	be file	IMP

	1 - FOR STATE REGISTRAR	STATE OF MARYLA				EALTH AND	MENT	AL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEATH			. TIME OF DEAT	ГН	
	IANICE I	TURNER					SEP	tenba	_	YEAR	6:24	AM	
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In	yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH			.ACE (State or Fo	oreign	
	214-44-3330	□ M 2x5xF 48	YRS.	WONTHS	DAYS	HOURS MIN.		L 8 19	47		YLAND		
~	9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY,	TOWN C	R LOCATION OF	DEATH		9c. COUNT	Y OF DEA	TH		
0	ANNE ARUNDEL MEDIC	AL CENTER		ANN	NAPO	LIS			ANI	NE AI	RUNDEL		
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN D	R LOCAT	ION				Lı	Od, INSIDE CITY		
G	MARYLAND ANNE	ARUNDEL	GA	LESVI	LLE					- 1	LIMITS?		
AL	10e. STREET AND NUMBER				101	ZIP CODE			10g. CITIZE	_	AT COUNTRY?	-	
FUNERAL	880 GALESVILLE ROA	.D				20765			US	SA			
FU	11. MARITAL STATUS 12 1 Nover Merried 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED				NDENT OF HISPANIC DRIGIN? (Specify Yes or No— 14. RACE — American ifly Cuban, Mexican, Puerto Rican, etc.)					nn,	
BY	3 Widowed 4 Divorced	FORCES? 1 YES	res ^{XX}			2 ND Spec		riroani, ettaj		Specify:			
	15. DECEDENT'S EDUCATI	M	140	P KIND OF BILE	INESS (IND.)		BLACK						
ET	(Specify only highest grade con Elementary/Secondary (0-12)	No Do NOT advanta							16b. KIND OF BUSINESS/INDUSTRY				
4P	12th	O DIETITIAN CROWNSVILLE HO								HOSP'	TAL CF	NTER	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N				1001	LIND OF	112210	
BE (KENNETH F. BOSTON ELSIE H. BUTLER												
10	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
IOSEPH I. THENER 1880 GALESVILLE RD. GALESVILLE, MD. 20765													
20a. METHOD OF DISPOSITION XX Buriel 2 Cremation 3 Removal from State										Stata			
	12/1-	MARIO	20	RE	EESE	& SONS	MORT	-					
-	mary -					EST ST.					L		
	23. PART i. Enter the diseases, or com ahock, or heart failure. List	only one cause on each	the death. Do r ch line.	101 enter	the mod	de of dying, su	ch aa ca	rdiac or reapli	ratory arres	A,	Approximation Interval B	etween	
	iMMEDIATE CAUSE (Final disease or condition	11/4	17.	1	7	1					Onset and	Death	
	resulting in death) a. I Cult (esq. n cfo m Districts Syndnone days) DUE TO (OR AS A CONSEQUENCE OF):										5		
_	- Per operal Uniceda Directa											Solue	
임	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):									Shin		
₫	CAUSE (Disease or Injury	a Diabetes									3YRS.	plas	
빌	that initieted events resulting in death) LAST	DUE TO (DR AS A C	F. 1								2 11	1	
CERTIFICATION	d	KEMM	1-201	ne							3-40	lays	
	PART ii. Other algnificent conditions conditions	ontributing to deeth bu	t not reaulting	in the un	derlying	ceuse given in	Part I.	24a, WAS AN			ERE AUTOPSY FI		
PHYSICIAN: MEDICAL								1 TYES 2		C	MILABLE PRIOR OMPLETION DF (F DEATH?		
ME					_			l			YES 2 F	10	
ÿ	DID TOBACCO USE CONTRIB			S D N		UNCERTA	N 🗆						
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE DF DEAT	OTHER	:								
¥.	1 VES 2 NO 1	Inpatient 2 ER/Outpat	tient 3 DOA	T .	ing Home	5 Residence	_						
	1 Natural 5 Pending	(Month, Day, Year)		URY	WOI		28d. DE	SCRIBE HOW IN	JURY OCCU	RED			
BY	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY -	- At home, farm, a	street, facto			28f. LO	CATION (Street e	nd Number or	Rural Rou	to Number		
COMPLETED	4 Homicide 8 Could not be	building, etc. (Specif)	y)				C/h	or Town, State)				- 1	
٣	29a. CERTIFIER CERTIFYING PHYSICIAN	N: To the best of my knowle	doe death occurr	ed at the th	me dete	and place, and du	a to the or	unada) and man					
N N		on the base of exemination									nd menner ee si	ated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	1//				29c. LICENSE NU					forth, Day, Year)		
BE	X tow Her Up.	Mh Ph.	D. D	6/		H36	076	.) (1/0	Contin, Cray, Teals)		
임	30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type,	Print)		11/0	18		/	17	0		
	STEURN D. Ful	la 900	Kreta	NE	Ro	1. Lu	nte	300 1	Ann.	1.	MD.		
	31. DATE FILED (Month, Day, Year) 1995	32. REGISTRAR'S SIGNAT	URE			1			11 4 10 1	AD.	21111	,,	
	001 00 1999	Java diwala	ALANDARA								2,40	1	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

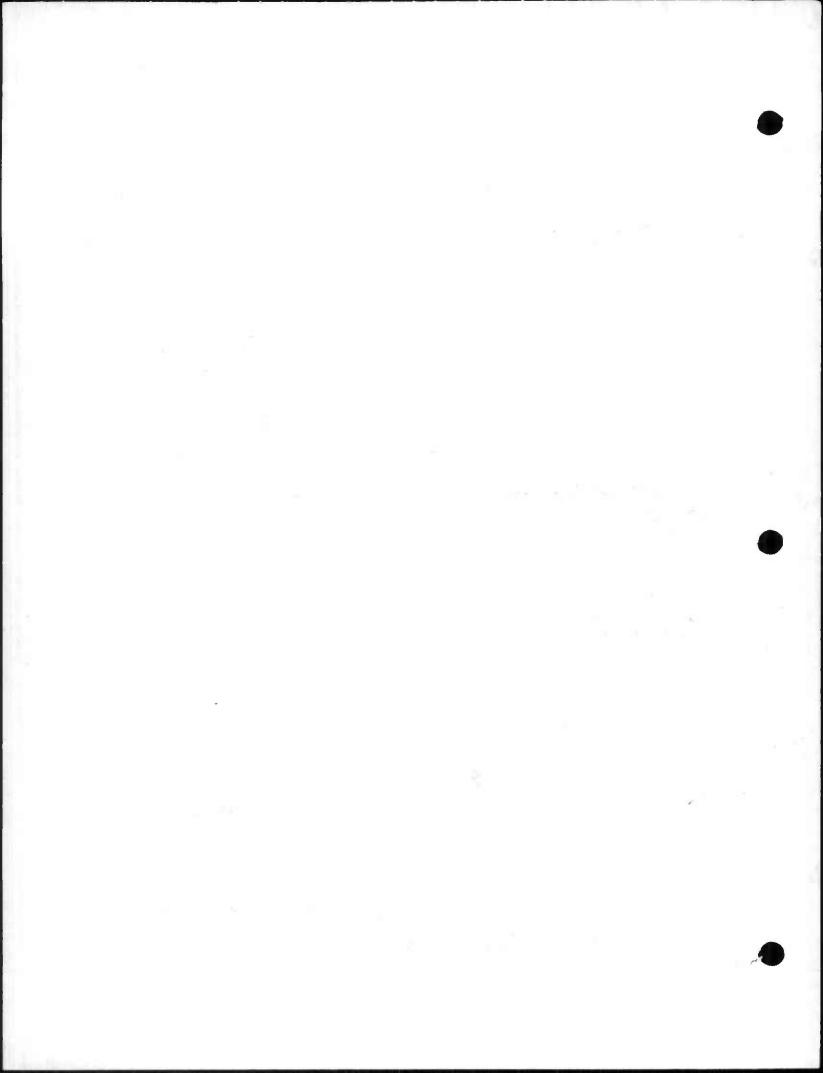
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REGISTRAN			EHIIF	ICALE	OF	DEATI	H	REG	i. NO.		
1. DECEDENT'S NAME (First, Middle, La SIDNEY	JACK SO	N TA	YLOF	?				2. DATE OF DEA		1995	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5, SEX	6. AGE (In yrs. Ia			MEAN T		\rightarrow				
216-40-4141	1 € M 2 □ F	5.4 Sec. (III yrs. Ia	YRS.	IF UNDER 1	DAYS	IF UNDER 24	MIN.	7. DATE OF BIRT (Month, Day, Y	bar)	Count	
9e. FACILITY NAME (If not institution, give		J4	ina.	AL 01-				June 15,			yland
		D								COUNTY OF DEATH	
RESIDENCE OF DECEDENT		ע.		SAL	1721	BURY			W	ICOMI	.CO
10e. STATE 10b. COU			10c. CIT	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY	
	comico		5	Salist							LIMITS? 1 YES 2 NO
100. STREET AND NUMBER 27420 Walnut T 11. Marital Status	ree Rd.				101.	21801	1	10g. CITIZEN OF USA			WHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT			13. W	AS DECE	NDENT OF	NISPANK	C ORIGIN? (Spec	Ify Yea or No	0 14. RAC	E American Indian.
1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1	X YES 2 NATES NAVV	NO	1 TYES 2 NO Specify:						Spec Wh	
15. DECEDENT'S E	DUCATION	16a, DI	ECEOENT'S	USUAL OCC	CUPATIO	N		16h KIND (AE BIJSINES		ite
15. DECEDENT'S E (Specify only highest on 12) Elamentary/Secondary (0-12) 1 2 17. FATNER'S NAME (First, Middle, Last)	nde completed)	(0	CECENT'S USUAL OCCUPATION 16b. KIND OF BUS the kind of work done during most of working Do NOT use retired.)					A BOSINES	S/INDUSTRY		
12	College (1-4 or 5+)						ET	Dupo	n t	
17. FATNER'S NAME (First, Middle, Last)		1 00									
	Taylor			18. MOTHER'S NAME (First, Middle, Maiden Surname)							
INCOMENTED HAME OF THE PARTY	Taylor			Lillian Duck MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code)							
190. INFORMANT'S NAME (Type/Print)	Reba E. Taylor										1001
Reba L. Taylor							e K	d., Sal			
20e. METHOD OF DISPOSITION 1 M Burlel 2 □ Cremetion 3 □ R	emoval from State	20b. PLACE cemetery, cre	AND DATE (of DISPOSIT	ION (Ner	ne of				N — City or To	
4 Donation 6 Other (Specify)		Sil	oam Cemetery 9/29 Siloam, MD)	
21. SIGNATURE OF PUMERAL SERVICE		22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home									
man-	10//	m	_					Rd., S		MI	0.1001
disease or condition resulting in death)											
Sequentially list conditions, If any, leading to immediate D. OUE TO (DR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c										
that initiated events	DUE TO (OR AS A CONSE	OUENCE OF	7):							
I readiling in death) EAST	reaulting in death) LAST										
	ons contributing to	deeth but not a	resulting I	n the und	erlying	Cattee oly	no in P	ert I 240 W	AS AN AUTO	nev out	. WERE AUTOPSY FINDINGS
PART II. Other significant condition					onymig	ondeo giv	011 111 1	PI	RFORMED?		AMAILABLE PRIOR TO
								- 190	ES 2 N	0	COMPLETION OF CAUSE OF DEATN?
								- hu	done	6	1 YES 2 NO
DID TOBACCO USE CON	ITRIBUTE TO CAI					UNCER	RTAIN	0.	6 ()	1	*
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEAT	N (Check on							
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XIXYES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 I	ER/Outpatient 3	□ DOA	OTHER:	g Nome	5 X Reeld	dence 6	Other (Specify	y)		
27. MANNER OF DEATH	28a. DATE OF I	INJURY W. Ward	26b. TIM	E OF 21	8c. INJU WOR	RY AT		28d. OEŞCRIBE I	IOW INJURY	OCCUREO	- 0
1 Natural 5 Pending 2 Accident Investigatio	14	1/24/91	704		1 Y		NO	Silvie	145	mot c	e Rt
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF	INJURY — At he	ome, ferm, s	treet, factor	y, office		1	281. LOCATION (S	Street and Nu	imber or Rural I	Route Number
4 Homicide determined	7	erc. (Specify)						City or Town,	Stote)	XT.	Rad
29a. CERTIFIER	SICIAN: To the best of								Walls	PM Ch	Will of
	NER: On the basis of ex									to the cause(e	e) end manner ee stated.
W 20h SIGNATURE AND TITLE OF CERTIF	IER 11					29c. LICENS	SE NUMB	ER	29d.	DATE SIGNED	(Month, Day, Year)
Theodore	M. K.	il un	1			O.C	.M.	E	•	SEPT	. 25,1995
30. NAME AND ADDRESS OF PERSON N	VHO COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type.	Print)			_				
THEWOREN	11K,-9	111	Pen	n St	ree	t, B	alt	imore	, Ma	rylan	d 21201
31. DATE FILED (Month, Day, Year)	32. REGISTRAF									-	
SEP 2 7 199	15 I Talin d'a	welson Ra	rdall								



TO THE HOSPITAL DA ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the study attended to the funeral director, page 5 should be detached to the funeral director and the funeral detached to the funeral detached to the funeral detached to the funeral director and the funer	IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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TO T	D T	M M

1. DECEDENT'S NAME (First, Middle, Last) FRANKLIN	W		DMPSON		REG. N 2. DATE OF DEATH MONTH SEPTEMBER	DAY .	+ YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 222-34-8900	5. SEX 8. A	GE (In yrs. last birthdi 47 YRS	MONTHS DAVE		7. DATE OF BIRTH (Month, Day, Year) 9/15/48		9. BIRTHPLACE (State Country) Milford,			
University of Mar		ital	96. CITY, TOWN Baltin	n or location of bi	EATH			ry of DEATH timore		
10a. STATE 10b. COUNTY De Ken	t		CITY, TOWN OR LOC	CATION		10d. INSIDE CITY LIMITS? 1 YES 2 X NO				
1745 Sportsman R	d.			19943			USA	EN OF WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O		If yes,	specify Cuban, Maxico	ENDENT OF HISPANIC ORIGIN? (Specify cuban, Maxican, Puarto Rican, etc.) 2 XNO Specify:			- American Indian, White, atc.		
15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12	CATION completed) College (1-4 or 5+)	(Give kind life. Do NO	or usual occupal of of work done during of use retired.)	nanic		x Fam	ily P	ly Products		
17. FATHER'S NAME (First, Middle, Last) Norman Thompson		1		Glenna	(Messick) Tho	mpson	ı		
Gerry M. Thomps	on									
20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Remo	ovel from State		Cemeter		1	- City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LIC	Mol	4		AND ADDRESS OF FA						
1,0,000	. Meli	n		vin Funer 22 S.duPo	al home nt Hwy, H	arrin	gton.	De 19952		
23. PART I. Enter the diseesea, or c shock, or heart failure. I	complications that certain only one cause of	on eech ilne.	155 Do not enter the	22 S.duPo mode of dylng, suc	nt Hwy, H			De 19952 Approximats Interval Batwee Onset and Dast		
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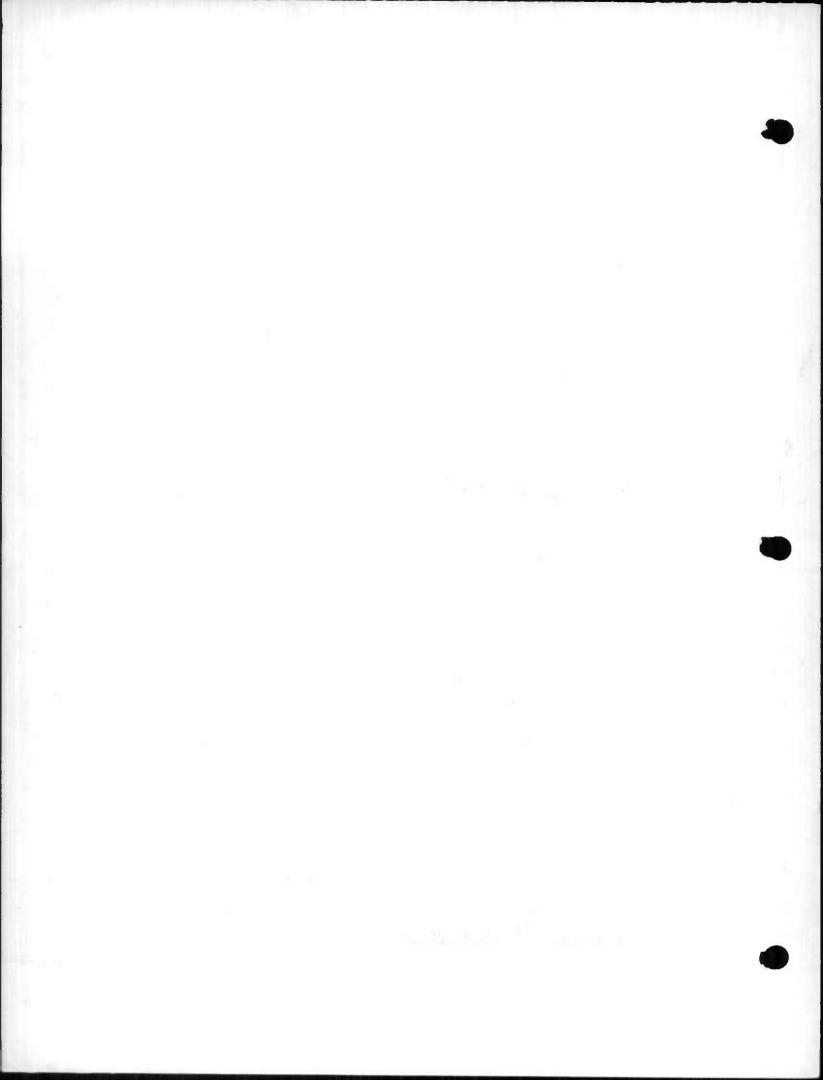
CLARENCE

37 REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print)

CLARENCE SARICOSEE - NEWO.

BALTIMURE



FOR STATE REGISTRAR

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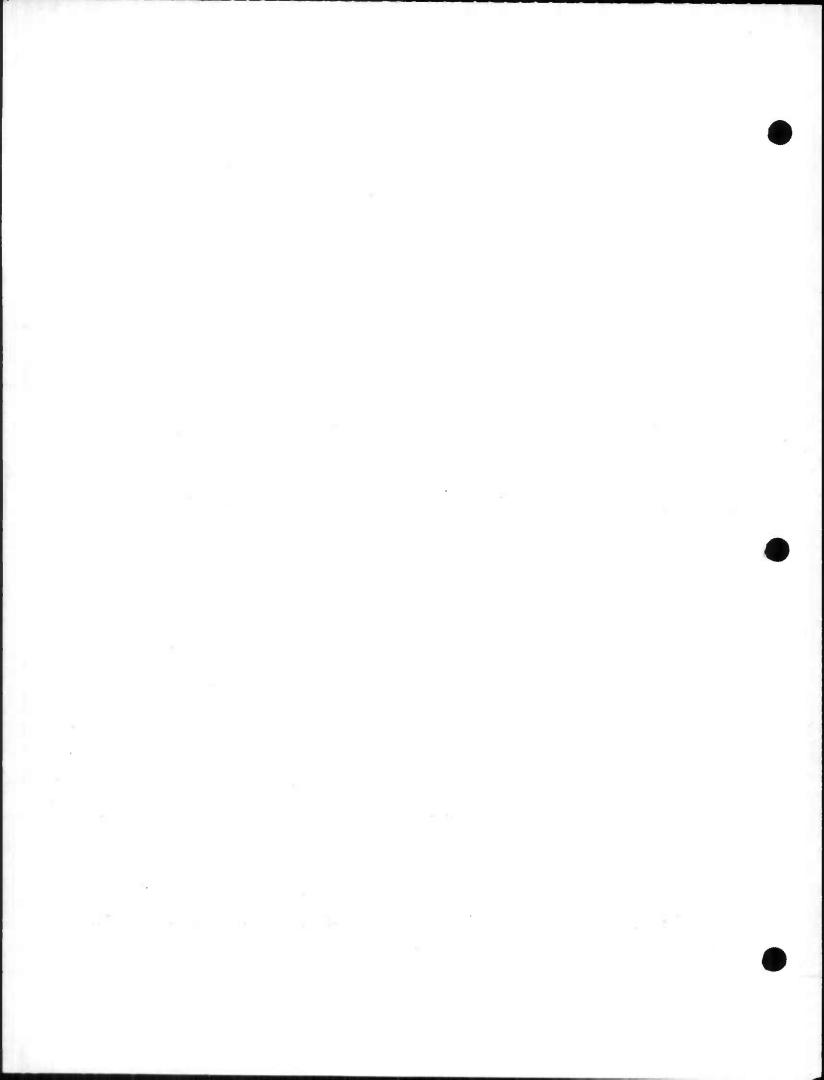
DHMH-16 Rev 1/89

24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3 should		1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATH SEPT 14 1995				TIME OF DEAT		
		JOSEPH		Sherwood TAYLO											2335	Рм	
		4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In		MC	ONTHS I	EAR DAYS	IF UNDER 24 HF	IN.	7. DATE OF (Month, D	Pay, Year)	}	Country)	ACE (State or For	eign
	1	213-19-3935		1 x M 2 F 20		20	YRS.					September 16		6,1974 Mary		yland	
	~	9a. FACILITY NAME (If not in		,			9	9b. CITY, TOWN OR LOCATION OF									
ci .	СТОВ	RIVERSIDE		/E				SALISBURY				WICOM			OMIC	:0	
ges 1,	EC	10e. STATE	10b. COUNTY				10c. CITY, TOWN OR LOCATION								od. INSIDE CITY		
F. Pa	DIRE	Maryland Wicomico				Salisbury									X YES 2	NO	
Decil	ERAL	10a. STREET AND NUMBER					10f. ZIP CODE								F WHAT COUNTRY?		
ansit	ij.	428 Priscilla St.					21801				USA			A			
ırial-tı	FUN	11. MARITAL STATUS 1 X Never Married 2 Married 12. WAS DECEDENT EVER I FORCES? 1 YES			YES	S 2 NO If ye		3. WAS DECENDENT OF HISPANIC ORIG If yes, specify Cuben, Mexican, Puerl				erto Rican, atc.)			ACE — American Indian, lack, White, atc.		
as the burial-transit permit. Pages	BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OF			MAR OR DA	1 🗆			1 YES 2 X NO Specify:							ite	
88	BE COMPLETED		EDENT'S EDU			16a. DECEDENT'S USUAL OCCU						16b. K	16b. KIND OF BUSINESS/INDUSTRY				
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ched		11				Dry Wall		Instal				Constru					
detach		17. FATHER'S NAME (First, Middle, Last) Joseph Sherwood Taylor Sr											First, Middle, Maiden Surname) Ann Peacock				
uld be		Joseph Sh	erwood	laylo	r Sr.	_									0.43		
5 should notified	6	Joseph S.	,,	Sr						and Number or R							
page pe		20a. METHOD OF DISPOSIT	ION		20b.	_	DATEOF				- 0	OATE	V	CATION — C		n, State	_
must	ì	1 KBurial 2 Cremation 3 Removal from State cemet				etery, cremetory or other place) oringhill Memory						9/19 Hebron, MD					
iner iner		21. SIGNATURE OF NERAL SERVICE LICENSEE					22. NAME AND ADDRESS OF FACILITY										
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use Heath and Memal Hygiene prior to buntal, cremation, or removal. was any injury, or other traumatic event, the medical examiner must be notified at once.		Colloway					Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 2180							2 1801			
		A PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												nte			
	1	shock, or haart fallure. List only one cause on each line.								Onset and							
the the		disease or condition															
nd completeh burial, crema itic event,		DUE TO (OR AS A CONSEQUENCE OF):															
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sician and co	CATION	Sequentially list conditions, If any, leading to immediate Cause Enter LINDERLYING										i					
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by the attended ind Mental	EDICAL	PART II. Other algnificant conditions contributing to death			daath bu	but not resulting in the underly			eriyin	Ing causa givan in Pi			PERFORMED?		24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION DF CAUSE		TO
gned by safth and	ŏ											1 YES 2 NO		OF DEATH?			
	Σ	DID TORACCO LISE CONTRIBILITE TO CALISE OF DEATH VES TO ALC DE LINICEDTAIN TO								1	1 YES 2 NO						
Dept.	IAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one)															
State	23. WIS CASE HEPERHED TO MEDICAL EXAMINER? XXYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence XXother (Specify) ACCIDIT										ENT	SCENE					
the the	ΞI	27 MANNER OF OFATH 28e DATE OF INJURY 28b TIME OF 28c INJURY AT 28d DESCRIBE HOW INJURY OCCURED															
r this th witt	ву Р	1 Netural 5 Pending (Month, Day, Year) 1813						JURY WORK? 1 □ YES 2 NO				DRIVER OFGER STRUCKTRIE					
r deal	0 8	2 Accident 3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, farm, a building, atc. (Specify)					ne, ferm, etr					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
TO THE FUNEPAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of IMPORTANT: If Hem 28 is marked, or Hem 23 she	ETE	4 Homicide detarmined ROSPWAY						RIVERSIDEDA WICOMICO +							UP		
DIRE HOUR	MPLE	29e. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.															
VERAI	COM	One) 2 X MEDICAL EXAMINER: On the beale of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated												tated.			
d with	ш	24. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENS			29c. LICENSE	E NUM	NUMBER 29			d. DATE SIGNED (Month, Day, Year)		
DE FIE	00	layre Whelfull					0.C.M			M. 1	E. SEPT.1				5,199	5	
	5	30. NAME AND ADDRESS O		/ *	USE OF OE	ATH (ITEM	27) (Type, P	rint)									
		HDWAR	OP 13	1-170hen	C IMO	N.	Peni	n St	re	et, B	Bal	timo	re,	Mary	land	2120	1
	3	31. DATE FILS EP 2	T1995	3	westpoor awater	P											
		1		7,000	- CONTRACTOR	L. WILLIAM	416										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

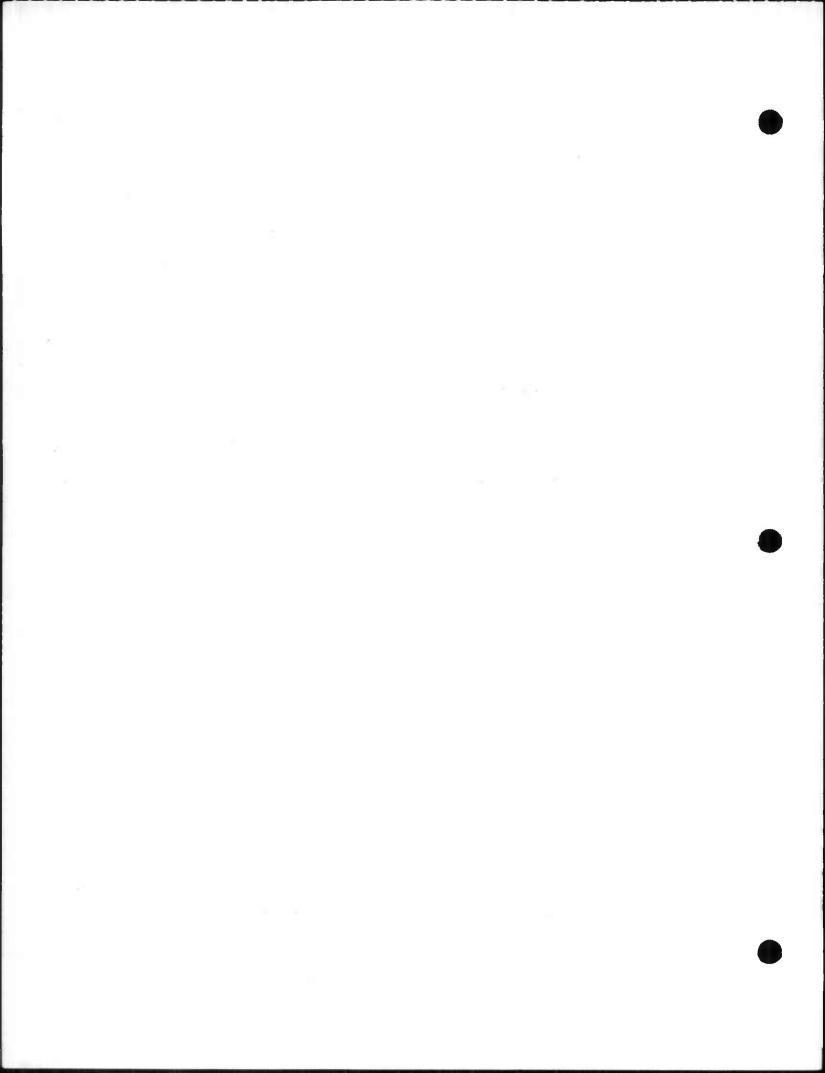
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

	REGISTRAR	CERTIFIC	ALE OF D	EATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH				
	EDITH A.	TYLEE			Sept. 1		12:40 1				
				UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRT	HPLACE (State or Foreign				
	059-20-569/10M2XDF	7 9 YRS.	CALL OF THE	Johns Min.	12/16/15						
	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR L	OCATION OF DEA	ATH	9c. COUNTY OF	DEATH				
O	6122 Palmer Mill Road	_	Hurlo	ck		Dorchester					
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d INSIDE CITY										
DIRECTOR	Maryland Dorchester	100. 0111,	TOWN OR LOCATION		- 1-		10d, INSIDE CITY LIMITS?				
9	10e. STREET AND NUMBER		104 311	Hurloc	2 K		1 YES 2 NO				
FUNERAL	Ficher For Serie		101. 211	WHAT COUNTRY?							
岁	6122 Palmer Mill Road 11. MARNITAL STATUS 12. WAS DECEDENT EVER IN			21643 United Sta							
	t Never Married 2 Married FORCES? t YES	2 NO			C ORIGIN? (Specify Yes, Puerto Ricen, etc.)	or No 14. RAC Bla	CE — American Indian, ck, White, atc.				
B	3 XWidowed 4 Divorced IF YES, GIVE WAR OR DA	ATES	1 TYES 2X	NO Specify:		Spe	c#y: White				
	15. DECEOENT'S EDUCATION		16h KIND OF BUS	I BINESS/INDUSTRY							
(Specify only highest grade completed) (Give kind of work done during most of working life by NAT userational to the specific of the specific											
2	Elementary/Secondary (0-12) College (1-4 or 5+) Sixth	Homema	ker		Own Ho	ome					
O	17. FATHER'S NAME (First, Middle, Last)		18	. MOTHER'S NAM	IE (First, Middle, Maiden	Sumame)					
0	Alvin Thomas Mon	an, Sr.			Shannon						
BE	19a. INFORMANT'S NAME (Type/Print)		DDRESS (Street and I		oute Number, City or Town	n State Zin Code)					
임	Mary Ann Dupree				Rd., Hui		MTD 21642				
	20a. METHOD OF DISPOSITION 20b	PLACEANDDATEOF				CATION — City or 1					
	A Donation 5 Other/Coseffe	etery, cremetory or othe			9-16 Fed	•					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	oncord	22. NAME AND A				arg, MD				
	> Marchand 7- Galen		Frampt	om-Haw	kins-Esk	ow Fun	eral Home				
	Tyocooning		Lo Rox	43, F	ederalsh	ourg, M	D 21632				
	23. PART I. Enter the diseases, or complications that caused shock, or heart failure. List only one cause on e	the desth. Do not schillne.	enter the mode	of dying, auch	aa cardiac or reapi	ratory arrest,	Approximata Interval Between				
1	IMMEDIATE CAUSE (Final disease or condition			0 /	· .	\cap	Opport and Doub				
ļ	disease or condition resulting in death) a. //Letastatic CA of Unknown Prikaty 245										
	DUE TO (OR AS A CONSEQUÊNCE OF):										
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
AT	If any, leading to immediate cause. Enter UNDERLYING	CONSCOULACE OF).									
윤	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A	CONSEQUENCE OF):									
F	resulting in death) LAST										
	u.										
EDICAL	PART II. Other algnificant conditions contributing to death by	ut not resulting in	ths underlying ca	use given in P	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO				
음	##TV				1 YES 2		COMPLETION OF CAUSE OF DEATH?				
ME						·	1 YES 2 100				
	DID TOBACCO USE CONTRIBUTE TO CAUSE O	F DEATH YES		UNCERTAIN							
S	FY A A A A A A A A A A A A A A A A A A A	26. PLACE OF DEATH									
Š	1 YES 2 NO HOSPITAL:		THER: Nursing Home 5	Masidence 6	☐ Other (Specify)						
PHYSICIAN:	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (AT	28d. DESCRIBE HOW II	JURY OCCURED					
BY	1 Naturel 5 Pending 2 Accident Investigation			2 🗌 NO							
	3 Suicide 8 Could not be 28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, atre	et, factory, offica		281. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,				
2	4 Homicide detarmined				on, or rown, orang						
COMPLETED	29a. CERTIFIER (Check only t CERTIFYING PHYSICIAN: To the beat of my knowledge)	edge, death occurred	at the time, data and	place, and due to	o the cause(a) and man	ner as stated.					
8							s) and manner as stated.				
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, day, Ye											
∞ ∥	296. SIGNATURE SIGN TITLE OF CENTIFIER	()/) []	444	15	01	18/95				
TO BE	1/00 1/an	ATH (ITEM 27) (Type, Pr	(int)	444	615	9/1	18/95				
ω	39 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Pr), (in) /	3/004	615	9/1	18/95 MD				
∞ ∥	1/00 1/an	2	ino E	444 3100m	inadale	Pd .	18/95 MD Fedtlausing				

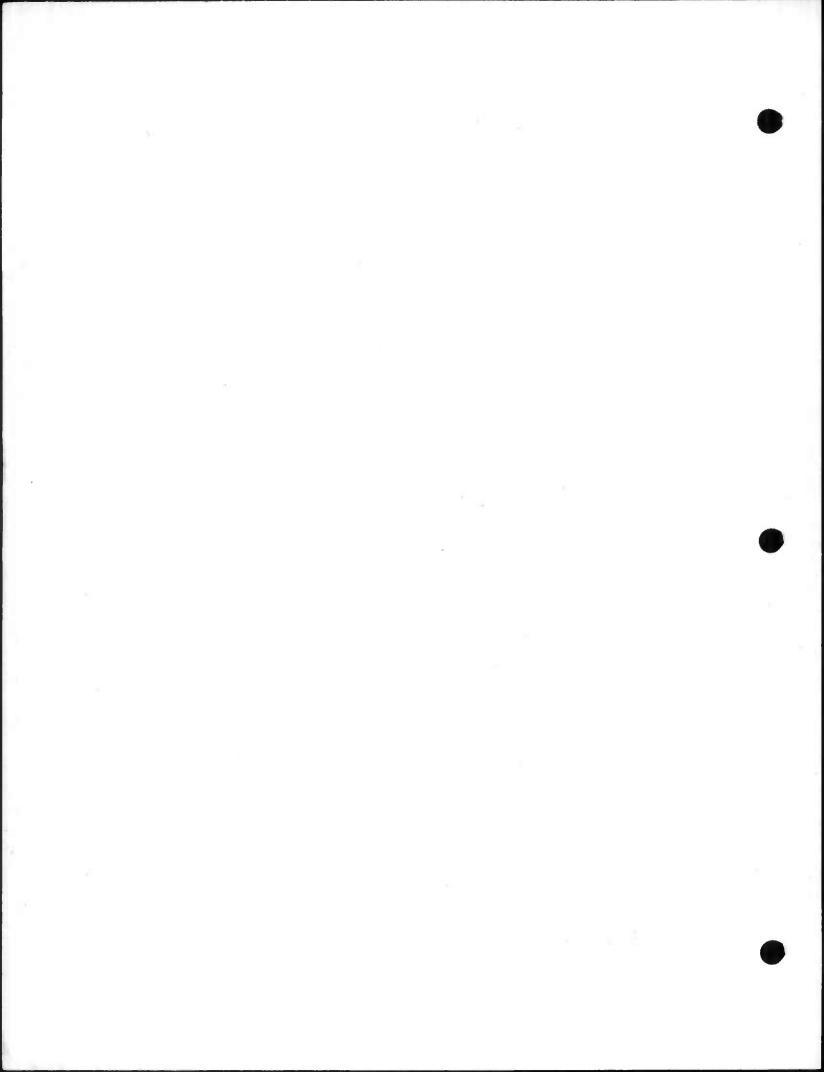


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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D THE HO	TO THE FUI	be filed with	IMPORTAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO

-	nedistran		OLN	ITIC	AIE OF	DEALH		REG. NO.			
	t. DECEDENT'S NAME (First, Middle, Last) Makga met	Ellen	thon	-			2. DATE O		- 6	YEAR 3	TIME OF DEATH
1	4. SOCIAL SECURITY NUMBER 577-12-8455	5. SEX 8. 1 M 2 F	AGE (In yrs. lest birth		NTHS DAYS	IF UNDER 24 HR	(Month,	Day, Year)	018	Country)	ACE (State or Foreign
	9e. FACILITY NAME (If not institution, give street and number)				Oct. 3, 1918						
DIRECTOR	Northhampton Nurs:				Frederick				Frederick		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY										
Ē					OWN OR LOCA	TION				1	Od, INSIDE CITY LIMITS?
	Maryland Freder	гіск	M	t. A						1	YES 2 NO
₹					100	of. ZIP CODE			10g. CIT	IZEN OF WH	AT COUNTRY?
9	402 Westridge Circ					21771			USA		(40)
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT ET	VER IN U.S. ARMED		13. WAS DE	CENDENT OF HIS pecify_Cuban, Me	PANIC ORIGIN	(Specify Yes	or No	14. RACE -	- American Indian, White, etc.
B≼	t Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 🗆 YE	S 2 NO Sp	ecify:	can, etc.)		Specify:	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Give kir	NT'S USU of of work OT use rel	AL OCCUPAT	ION lost of working	16b.	KIND OF BUS	SINESS/INC	DUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	self	Or use rae	meu.)		1	nomema	ıker		1
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden						
BE C	William Francis Ro	ock				E11a	France	s Har	riga	n	
	19a. INFORMANT'S NAME (Type/Print)		19b. MA	LING ADD	DRESS (Street	and Number or Ru					
임	Ann Rinker					e Circle				2177	1
	20a. METHOD OF DISPOSITION		20b. PLACE AND D	ATE OF D	SPOSITION /A	lame of				City or Town	. State
	1X Burial 2 Cremation 3 Remo	val from State	cemetery, cremetor Mt. Oliv	et C	Cemete	ry	199	Was	shing	ton.	D.C.
	21 SIGNATURE OF FUNERAL SERVICE LICE	NSEE			22. NAME A	ND ADDRESS OF	FACILITY ST	auffe	r Fu	neral	Home
1	- Dynu Mis	Derge	1								, MD 21702
	23. PART I. Enter the diseeses, Dr co shock, pr heart fallure. L	omplications that callst only one callse	on each line.	Do not e	enter the m	ode of dying, a	uch es cerdi	ec or reapl	ratory arr	reat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition			ь.		1.1					Onset and Death
	disease or condition resulting in death) a. Pulcinomic - Possible 24 hrs. Due to (or as a consequence of):										24 /1
	DUE TO (UN AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									Son	
¥	if any, leading to immediate cause. Enter UNDERLYING										10
Ĕ	CAUSE (Disesse or injury thet initieted events	DUE TO (OR	AS A CONSEQUEN	CE OF):							
ᇤ	resulting in death) LAST										
- 13	PART II. Other algolificant conditions	contributing to de-	nah hasa maa aa aa	11-06							
EDICAL	PAGE II. Other algumeant conditions	contributing to del	ITH DUT NOT result	ing in th	e underlyin	ig ceuse given	In Part I.	24a, WAS AN PERFOR		A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
١								t TYES 2	KHO		DMPLETION OF CAUSE F DEATH?
Σ	DID TODA COO LIST COALTO									1	☐ YES 2 ☐ NO
¥	DID TOBACCO USE CONTR	IBUIE IO CAUS					AIN 🗆				
PHYSICIAN:	EXAMINER?	HOSPITAL:	28. PLACE OF	ОТ	MER:						
Ž Ž	27. MANNER OF DEATH	1 Inpatient 2 I ER		_	_	ne 5 🗌 Rasiden					B-36
BY PI	1 Anatural 5 Pending 2 Accident Investigation	(Month, Day,)		INJURY		JURY AT ORK? YES 2 NO	26d. DESC	RIBE HOW II	NJURY OCC	CURED	
	3 Suicide 6 Could not be datarmined	28s. PLACE OF IN building, atc.	JURY — At home, fa (Specify)	rm, street	, factory, offic	ia .	28f. LOCA City or	TON (Street a Town, State)	nd Number	or Rural Rou	te Number,
<u> </u>											
COMPLETED	(Check only one) 29a. CERTIFIER 1 CERTIFYING PHYSICI (Check only one) 2 MEDICAL EXAMINER										nd manner as stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER	AluxY1-	111-			29c. LICENSE	NUMBER		29d, DATE	E SIGNED (M	Ponth, Day, Year)
٩	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM 27)	Type, Print	2/4	(40)	L.	1.	./	100	212.1
	31. DATE FILED (Month, Day, Year) SEP 2 9 1995	32. AEGISTRAR'S	SIGNATURE WISON-RONDA	/)	TOM) on	JV	9 en	el l	VIA	1101
	OLI & 0 1333	1 SIRO	ween harda	41							



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1	-	FOR STATE REGISTR	AR
1	. DI	ECEDENT'S	NA

	REGISTRAN				OLIN	ITICA	ILE OF	DEAT	п	REG. N	0.			
	1. DECEDENT'S NAME (First, Mid	C,	Urban								PAY 9	95	3. TIME OF DEATH AM	
	4. SOCIAL SECURITY NUMBER 800-07-0423		5. SEX 1 M 2 TF	6. AGE (II	n yrs. last birth	RS. MONT	HB DAYS	NOUTIS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	3 1 9	Count	HPLACE (State or Foreign Iry)	
	9e. FACILITY NAME (If not institut	tion, give st	reet end number)			9b.	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
DIRECTOR	MD. Manor C	onv.	Ctr.				Glen_	Burr	nie		Ann	Anne Arundel		
E	The second secon						TY, TOWN OR LOCATION						10d. INSIDE CITY	
DIA		Anne	Arund	e 1		Sev	Severna Park				LIMITS?			
I₹	10a. STREET AND NUMBER						10	. ZIP CODE			10g, Cl	TIZEN OF	WHAT COUNTRY?	
ļ	146 Truckhouse Rd.						21146				US	SA		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARMED		13. WAS DEC	ENDENT OF	HISPANI	C ORIGIN? (Specify)	es or No —	14. RACI	E — American Indian, k, White, etc.	
₽	1 Never Married 2 Mar 3 Widowed 4 Divorced		IF YES, GIVE W	AR OR DA	TES			2 KNO		, Puena Ricen, etc.)		Spec	etty:	
	15, DECEDE	NT'S EDUC	ATION		16a. DECEDE	NT'S USUA	L OCCUPATION	ON		16b, KIND OF B	USINESS/IN	IOUSTRY	White	
COMPLETED	(Specify only high	nest grade (College (1-4 or 5 -		(Give kin life. Do N	d of work d OT use retir	one during mo ed.)	st of working		-1105/2017 10:00	DECEMBER OF	STATE OF COLUMN		
၂립	12			´	Supe	ervi	sor			Garme	nt F	acto	orv	
O	17. FATHER'S NAME (First, Middle,	, Last)						18. MOTHE	ER'S NAM	E (First, Middle, Melde		a c c .	OLY	
E B	Herman		Kind	ler				Ame	lia		Van	kee		
BE	19e. INFORMANT'S NAME (Type/F	Print)			19b. MAI	LING ADDI	ESS (Street &			oute Number, City or To				
TO BE COM	Frances McA	1exa	nder										a. 22015	
	20a, METHOD OF DISPOSITION			20b.	PLACEANDD				. 1. 11		OCATION -			
	1 XBuriel 2 Cremetion 3 4 Donation 5 Other (Spe		wai Irom Stale	ceme	etery, cremator) en Ha	or other pla			0	1				
5	21. SIGNATURE OF LINERAL SE	EVICE LICI	PISEE	101	en ne		22. NAME AI	ND ADDRESS			еп в	urn	ie, MD.	
		1/~	5			Ì	Barra	anco	& S	ons Fun	eral	Ног	m e	
is e		160	Tura	س			495 I	Ritch	ie_	Hwy Sev	erna	Pai	rk MD21146	
5	23. PART/I. Enter the disee shock, or heart	sea, or co	omplications that list only one cau	ceused se on ea	the death.	Do not ei	nter the mo	de of dyin	g, auch	as cardiac or rea	piratory si	rrest,	Approximate Interval Between	
D .	IMMEDIATE CAUSE (Fine)			1.1							-		Onset and Geath	
5	disease or condition resulting in deeth)	a	nrob	abl	€ 0	ar	Lia	0 0	211	rhyth	219		coupe	
2			DUE 10	OR AS A	CONSEQUENC	CE OF):				0			12 may	
S	Sequentially list conditions		uro	Sep	SUS								hours	
Ě	if sny, leading to immediate cause. Enter UNDERLYING		DUE TO	(DR ASUA	CONSEQUENC	E OF):								
	CAUSE (Disease or Injury	1 c	DUE TO	OR AS A	CONSEQUENC	DE OED								
	that initiated eventa resulting in death) LAST		502.10	(OI AS A 1	CONSEQUENC	E OF):							į į	
CERTIFICATION		d												
	PART II. Other significent c	onditions	contributing to	death bu	it not result	ing in the	Underlying	g cause glv	ven in P	art i. 24a. WAS A	N AUTOPSY	24b	WERE AUTOPSY FINDINGS	
EDICAL	history	4	cereb	rel	har	noi	erhou	90	199	1 PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ME		U						0			Z IBE NO		OF DEATH?	
	DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF	F DEATH	YES [I NO F	UNCE	RTAIN				,	
PHYSICIAN:	25. WAS CASE REFERRED TO ME				8. PLACE OF						-			
Sic	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Oulpa	itient 3 🗆 DO		Nursing Hom	e 5 🗆 Reel	dence 6	Other (Specify)				
	27. MANNER OF DEATH		28e. DATE OF (Month, Di		28b.	TIME OF	28c. INJ	URY AT	T -	28d. DESCRIBE HOW	INJURY OC	CCURED		
BY	1 Netural 5 Pend 2 Accident Inves	fing stigation	I I I I I I I I I I I I I I I I I I I	ly, real)		INJUNY	1 0	RK7 YES 2 [NO					
	3 Suicide 6 Coul		26e. PLACE Of	F INJURY -	At home, fa	rm, atreet,	lectory, offic	•		281. LOCATION (Street	end Numbe	or Runel F	Route Number,	
TED	4 Homicide deler	mined	Danielly,	etc. (Specif	197					City or Town, Stet)			
1 2	290. CERTIFIER (Check only	NG PHYSIC	IAN: To the best of	my knowle	dge, death oc	curred at t	he lime, date	end place e	and due to	the ceuse(e) end m		de d		
COMPLET													e) end manner se stated.	
E C	29b. SIGNATURE AND TITLE OF		1						ISE NUMB		-		(Month, Day, Year)	
	ahm. D.	Xh	astek.	m-1	Ω			0 -	19	767	D /	dila	a ac	
입	30. NAME AND ADDRESS OF PER	SON WHO	COMPLETED CAUS	E OF DEAT	TH (ITEM 27) (Type, Print)			/ 1		1.0	111	1/2	
	Jerny D. S	rka	rbek. 7	A . D	. 84	18	B+A	BI	Vd.	Para	ana	M	1.21122	
	31. DATE FILED (Algorith, Day, Year)		32. REGISTRA	1				<u></u>		1.000	. 101	+	4	
	OCT 0	5 199	35 Asi	Dave	dear Ren	dall								
			1)										DHMH. 18 Pay 1/89	

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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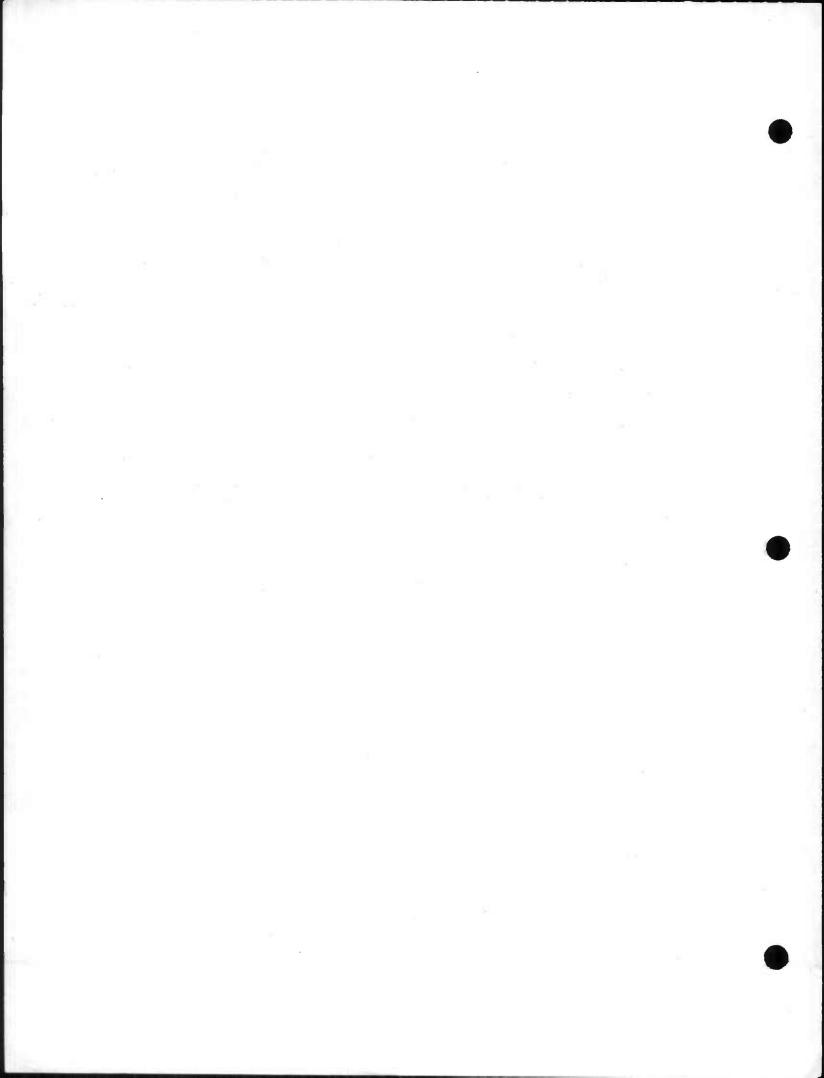
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		FOR
1	_	STATE
U.		REGISTRAR

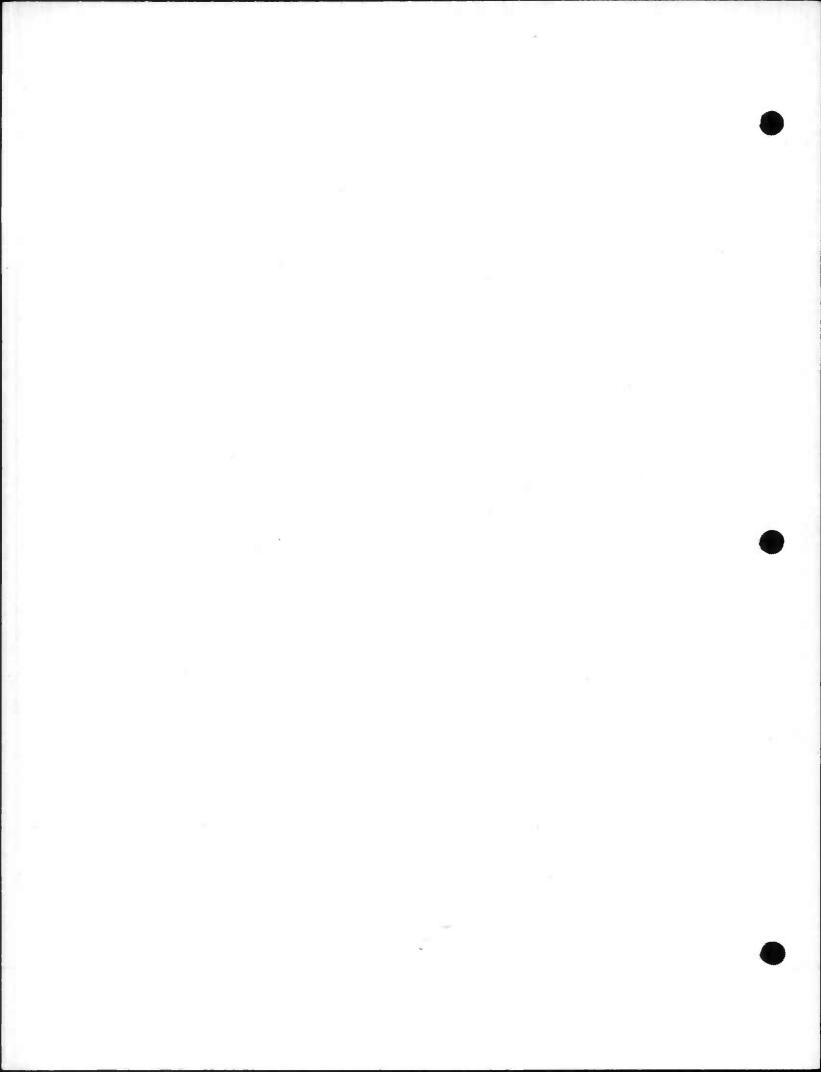
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		C	ERTIF	CATE	F DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Mary Loui	ico		V	ELLA		Sept.		L 9595	4:05 par	
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. la:		IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH			4:05 pan	
	221-18-4092	221-18-4092 1 □ M 2 🖫 F			MONTHS DAY	B HOURS MIN.	Feb. 19,	Feb. 19, 1917		Maryland	
m	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN OR LOCATION OF DEATH				INTY OF DEAT	Н		
DIRECTOR	Memorial Hospital	L		Easton				T	albot		
JEC	10a. STATE 10b. COUNT	Υ	10			CATION			10	d. INSIDE CITY LIMITS?	
	Delaware New	Castle			ewark				YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			101. ZIP CODE				10g. CITIZEN OF WHAT COU			
	54 Cheswald Boulevard					19713			S.A.		
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced				If yes	specify Cuben, Maxico (ES 2 NO Specification)	en, Puarto Rican, etc.		14. RACE	American Indian, /hite, etc. White	
	15. DECEDENT'S EDU		16a, Di	ECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF	BUSINESS/IN	DUSTRY		
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	e completed) Coflege (1-4 or 5+)	life and the second	Bive kind of v e. Do NOT us	vork done during e retired.)	most of working					
4	10		1	book	keeper		Harry	Kenyon	Vendi	ing Company	
Ö	17. FATNER'S NAME (First, Middle, Last)						AME (First, Middle, Ma				
BE	William Franklin	Griffin					la E. Bla			in	
0	19a. INFORMANT'S NAME (Type/Print) William F. Thomas		19			et and Number or Rural				10026	
	20a. METNOD OF DISPOSITION	>	20h BLACE		OF DISPOSITION			Layton -		aware 19938	
	*XSurial 2 Cremation 3 Ren 4 Donation 6 Other (Specify)	novel from State	cometery, cr	emetory or of	Cemete:	cy	9/24 R				
	21. SIGNATURE OF FUNEDAL SERVICE L	ICENSEE			22. NAM	AND ADDRESS OF F	CILITY				
	1/1/1/	IFO.	/			egle-Helfe Box 160				1 21620	
	23. PART i. Enter the diseases, or									Approximata	
	shock, or heart feliure. iMMEDIATE CAUSE (Final					_	1			Interval Between Onset and Death	
	disease or condition ERVICAL CA (Metastast) ?3										
	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING										
FIC	CAUSE (Disesse or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):										
E	resulting in death) LAST										
	PART II. Other significant condition	ne contributing to	death but not	moulting	in the under	vina čeuse alven is	Dort I 24a WA	S AN AUTOPSY	245 W	ERE AUTOPSY FINDINGS	
DICAL	X of	mia of	N	mic	Dz-	ying couse given it	PEI	REORMED?	AN	AILABLE PRIOR TO OMPLETION OF CAUSE	
ED		01	Call	· · ·			1 □ YE	s 200 NO	OI	DEATH?	
2	DID TOBACCO USE CONT	RIBUTE TO CAL	ISE OF DEA	ATH YE	S \square NO	☐ UNCERTAI	NΠ		Т.	1 4E3 20 NO	
AN	25. WAS CASE REFERRED TO MEDICAL				TH (Check only						
Sic	1 YES X	HOSPITAL:	ER/Outpatient	300 DOA	OTHER:	iome 6 Residence	6 C Other (Specify,				
PHYSICIAN: ME	27. MANNER OF DEATH	28a. DATE OF I	INJURY	28b. TIM	-	INJURY AT WORK?	28d. DESCRIBE N		CCURED		
BY	1 Natural 5 Pending 2 Accident Investigation		,,,			YES 2 NO					
	3 Suicide 6 Could not be 4 Nomicide determined	26a. PLACE OF building, s	INJURY — At h nc. (Specify)	iome, ferm,	street, factory,	office	281. LOCATION (Si City or Town,		er or Rural Rou	le Number,	
ET							<u> </u>	<u>.</u>			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS	SICIAN: To the best of a								nd manner as stated	
	29b. SIGNATURE AND TUTLE OF CERTIFI		and the second		ni, iii niy opnik	29c. LICENSE NU				Ionth, Day, Year)	
BE	Charling	ne				D4	2816	290.00	9/2	2/95	
2	30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type	, Print)	1			1	110	
	Richard Burgoy	ne, MD 60	7 Dutc	hman'	s Lane	Easton,	MD 2160	1			
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE								
	SEP 25 '95	gulia De	widson-A	andree							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

							30	3 3 1		
	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Caroline Elizabet	h Vanao	2020			2. DATE OF DEATH D. September	*X 0 =	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
	220–16–0977	1 🗆 M 2 💢 F 7		MONTHS DAYS	IONTHS DAYS HOURS MIN. MIN. M. YOUNG					
DIRECTOR	Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			ty of DEATH derick		
EC	10a. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LOCA	TION			10d. INSIDE CITY		
					ck		1 A YES 2 NO			
FUNERAL	10e. STREET AND NUMBER 321 Willow Avenue				21701			EN OF WHAT COUNTRY?		
N.		12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC		C ORIGIN? (Specify Yes		14. RACE — American Indian,		
ВУ	1 XXNever Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	Z/XNO TES	If yes, sp	ecify Cuban, Maxican 2 NO Specify:	, Puerto Rican, atc.)	, un 11.0—	Black, White, atc. Specify: White		
	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16a. OECEDENT'S	USUAL OCCUPATION	ON ast of working	16b. KIND OF BUS	SINESS/INDU	ISTRY		
COMPLETED	Elementary/Secondary (0-12)	# O HOT				Public	e Sch	ool System		
BE CO	17. FATHER'S NAME (First, Middle, Lest) John		18. MOTHER'S NAM Fanni	e Mae	Surname) O'Hai	ra				
TO	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Willow Ave., Frederick, Md. 21701									
	20s METHOD OF DISPOSITION 1	vat from State 20b.	PLACE AND DATE	of Disposition (Na Differ place)	ome of	DATE 20c. LO	cation – c	ity or Town, State		
	1 Burlet 2 Cremation 3 Removal from State Competery, Crematory or other closes Competery, Crematory or other closes Competery, October 2, 1995 Frederick, Marylar									
	* Richard E.	Drof M	00255					ral Home ck, Md. 21701		
	23. PART i. Enter the diseases, or co- shock, or heert fellure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in dasth)	Chronic	Obst	mot enter the mo	de of dylng, such	ss cardiec or respi	ratory srre	st, Approximata interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UMDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PART II. Other algnificant conditions Denshiral	Vascular	not resulting	In the underlying	g ceuse given in P	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
MED				/		1 TYES 2	NO	OF DEATH?		
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S NO L	UNCERTAIN					
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEA	TH (Check only one) OTHER:						
IYS	1 YES 2 NO	Inpatient 2 - ER/Outpe		4 - Nursing Hom	e 5 🗆 Residence 6					
	1 Natural 8 Pending	28a, DATE OF INJURY (Month, Day, Year)	286. TIM		RK?	28d. DESCRIBE HOW II	NJURY OCCL	JRED		
red BY	2 Accident trivestigation 3 Suicida 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Speci	At home, term,	street, tectory, offic	•	28f. LOCATION (Street a City or Town, State)	nd Number o	r Rural Route Number,		
COMPLETED		AN: To the best of my knowle On the basis of examination						d. cause(s) and manner as stated.		
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUME			SIGNEO (Month, Day, Year)		
TO BE	A46 J. W.S	n			D265	716	►Se	PT 29 1995		
	36. NAME AND ADDRESS OF PERSON MICHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	TAY	NEY	Ne	(RED MD		
	OCT 0 2 1995	22. HAGISTRAJI S SIJAN	or Real 10							



Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

BALT	death.
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_	hours
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6876	executed
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.O. B(certificate
S.	death
Ö	the
E C	that
RECC	requires
	MP
Z	He H
<u></u>	AN:
0	PHYSIC
DIVISION OF VITAL RECORDS, P.O. BOX 68760	IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death,
\leq	OR /
_	PITAL
	HOS

HUBERT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Idred ebb IrqiniA 995 11:10 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAVE 212-16-1009 1 M 2 X F 86 May 20, 1909 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Glasgow Nursing Home Cambridge Dorchester RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Cambridge permit. 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 111 High Street 21613 U.S.A. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 X Never Merried 2 Married В 1 TYES 2 NO Specify: Specify. 3 Widowed 4 Divorced use as the White E 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only high Ē the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 4 Writer Private Newspaper notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Watson Webb 图 Mildred Woolford 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Richard D. Harrington Box 253, Cambridge, MD. 21613 P.O. pe 20a METHOD OF DISPOSITION
1 A Burlat 2 Cremetion 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 26c, LOCATION - City or Town, State DATE must Christ 4 Donation 5 Other (Specify) Episcopal Ch Cem 10-4 Cambridge, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Curran-Bromwell Funeral Home, 308 High St. Cambridge, medical 23. Man . Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by Approximate shock, or heart failure. List only one cause on each line. interval Between 0 IMMEDIATE CAUSE (Final Onset and Death the cremation, disease or condition_ CONGESTIVE HEART FAILURE resulting in death) event, DAYS burial, HEROSCIZEDOTICV ASCULAR DISENSE traumatic CERTIFICATION and Sequentially list conditions, OUE TO (OR AS A CONSEQUE prior to If any, leading to immediate cause. Enter UNDERLYING attending physician PONK OBSTRUCTIVE PULMONARY 125 other 1 CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) DKEMSE that initiated events resulting in death) LAST 6 Mental in ury, the PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and i PERFORMED? shows any MAILABLE PRIOR TO Signed Health a COMPLETION OF CAUSE 1 TES 2 1 1 YES 2 NO has been ō DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D Dept PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate State EXAMINER? HOSPITAL: OTHER

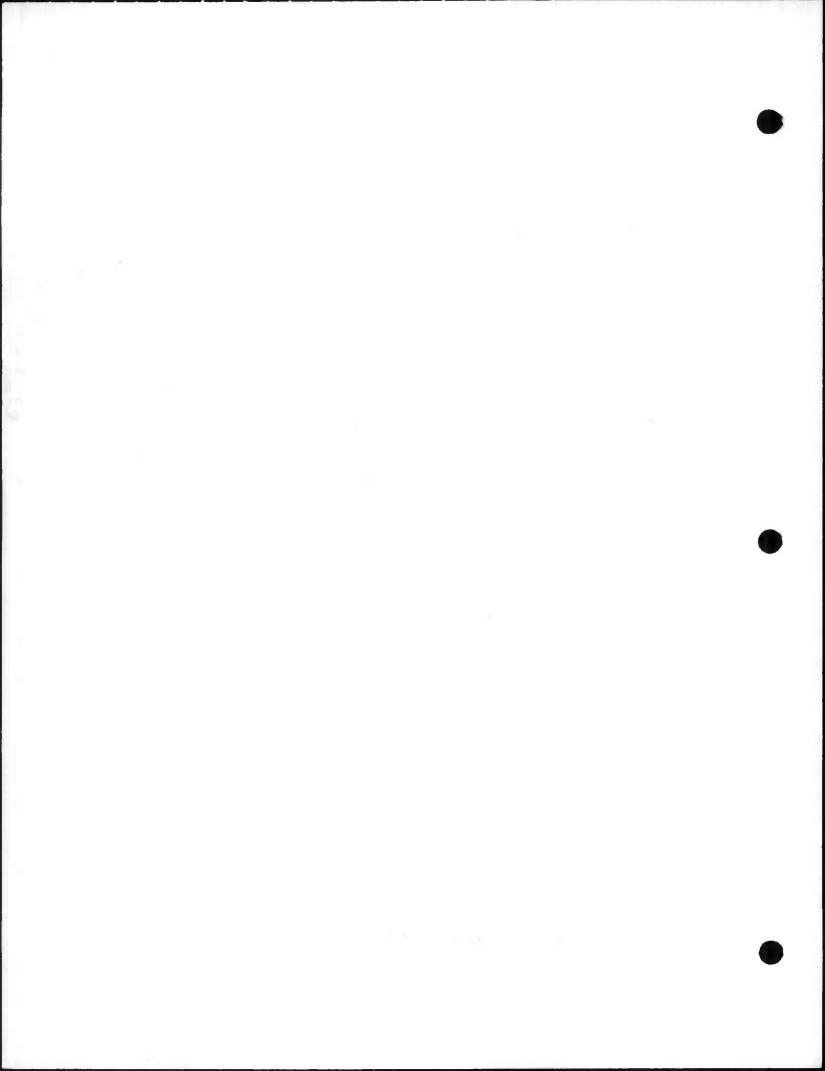
4 Nursing Home 5 Residence 6 Other (Specify) 1 - YES 2 - NO 1 Inpatient 2 ER/Outpatient 3 DOA the 0 27. MANNER OF CEAR 28e. DATE OF INJURY with 1 marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Meterol 1 YES 2 NO death BY DIRECTOR: After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) S 3 Sulcide 28f. LOCATION (Street and Number or Rural Floute Number, City or Town, State) COMPLETED a Could not be after 4 Homicide 28 hours item 29a. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated, TO THE HOSPITAL TO THE FUNERAL IT DE FIED WITHIN 72 h 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D ATH JEM 27) (Type, Print)

503

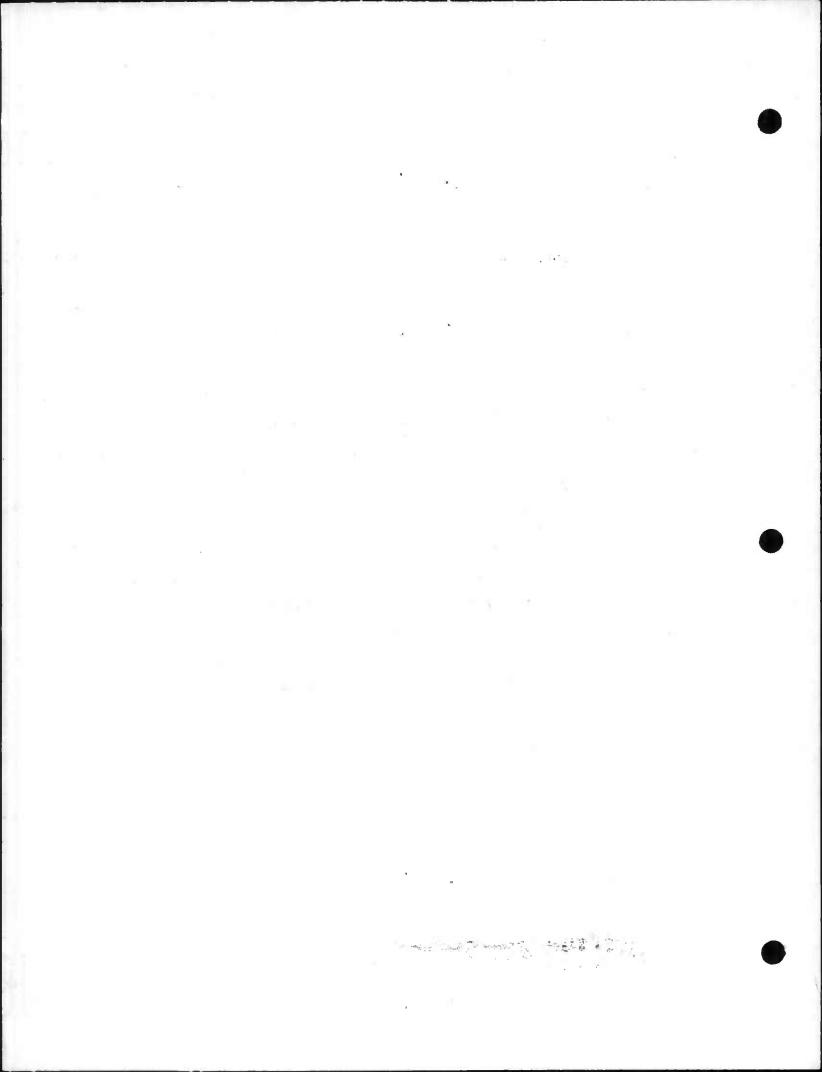
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BYPW ST

CAM B PUDGE



	1. DECEDENT'S NAME (First, Middle, La	-		ERTIFIC	ATE O	r DEAI		REG. NO			
	AH-GAM WOO	ist)						month Ctober	7 1	995	3. TIME OF DEATH 3:52 a
	4. SOCIAL SECURITY NUMBER 579-42-6644	1 🔀 M 2 🗆 F	AGE (In yrs. Ia		ITHS DAYS			Month, Day, Year)	29	Count	HPLACE (State or Foreign ry) on, China
OR	99. FACILITY NAME (If not institution, glassical Southern Mary)	ve etreet end number) land Hospi	tal(Center		inton				CE (Georges
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COU			10c. CITY, TO	WN OR LOC	CATION					10d. INSIDE CITY
	Maryland Mo	ontgomery		Wheaton 101. ZIP CODE 100. CITIZEN OF W					LIMITS?		
FUNERAL	11503 Bucknell	Drive		101. ZIP COOE 109. CITIZEN OF USA						WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR ON NO	YES 2	NO If yes, specify Cuben, Mexic				INIC ORIGIN? (Specify Yes or No— 14, R an, Puerlo Rican, etc.)			E — American Indian, k, White, etc.
TED	15. DECEDENT'S E (Specify only highest gr		16a. Di	Ba. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BU	SINESS/IND		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	e (1-4 or 5+) life. Do NOT use reti						Restaurant		
	17. FATHER'S NAME (First, Middle, Lest) Unobtainable						First, Middle, Maiden	Sumeme)			
O BE	19e. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADD	RESS (Street		btair * Aural Route	Number, City or Tow	n, State, Zip	Code)		
2	In Chan Kim		1	11503 B	uckne	11 Dri	ve, W	Meaton,	Md.2	0902	
	20e, METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 R 4 Donation 5 Other (Specify)	cametery cre	AND DATE OF DI	Jace)				CATION —			
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Fali	fax Me		AND ADDRESS			airt	ax,	Virginia
	+ Michel I	Kojam									HOME, INC. a. 22180
	IMMEDIATE CAUSE (Finel		used the de	eath. Do not e	enter the m	node of dyin	g, auch as	cerdiac or respi	ratory arr	rest,	Approximata interval Batwe
	disease or condition										Onset and Dat
	disease or condition resulting in death)		AS A CONSE	OUENCE OF):				**			
ATION	Sequentially list conditions, if any, leading to immediate	- Metasta	tic c	OUENCE OF): Cancer QUENCE OF):	to	left	clav	**	apul	la	
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events	DUE TO (OR DUE TO (OR L4 Verte DUE TO (OR	AS A CONSE AS A CONSE ebrae AS A CONSE	OUENCE OF): Cancer QUENCE OF): 2 / live OUENCE OF):	to r an	left d kne	clav es.	icle,sc	apul	la	months
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MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are also and the capture of the conditions of the capture of the ca	Metasta DUE TO (OR L4 Verte DUE TO (OR Uncontro d. Uncontro Cachexia	AS A CONSE AS A CONSE ebrae AS A CONSE Olledon oth but not in , ane	Cancer ouence of: e, live ouence of: e, live ouence of: l diab resulting in the	to r and etes e underlyi hype:	left d kne mell ng cause glv rcalc	clav es. itus ven In Pari emia	icle, sc	AUTOPSY IMED?		YEARS. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION DF CAUSE
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST PART II. Other algnificant condit dehydration. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DANO	Metasta DUE TO (OR L4 Verte DUE TO (OR Uncontro d. Uncontro Cachexia	AS A CONSE tic C AS A CONSE ebrae AS A CONSE Olled oth but not i ane E OF DEA	Cancer Quence of: Quen	to r and etes e underlyi hype: NO[heck only one HER:	left d kne mell ng cause glv rcalco	clav es. itus ven In Pari emia RTAIN [icle, sc	AUTOPSY IMED?		Weeks. Wears. Wears.
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ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condit chydration. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	DUE TO (OR Metasta: DUE TO (OR L4 Verte DUE TO (OR Uncontre d. Iona contributing to dee Cachexia NTRIBUTE TO CAUSI HOSPITAL: 1 Ninpetient 2 ERV 280. DATE OF INJU (Month, Day, Ye base 280. PLACE OF INJU Duliding, etc.	AS A CONSE tic C AS A CONSE ebrae AS A CONSE Olled th but not i , ane E OF DEA 26. PLAC (Outpetlem 3 JURY — At ho	Cancer QUENCE OF: QUEN	to r and etes e underlyi hype: NO[heck only one HER: Nursing He 1	left d kne mell ng cause giv rcalc UNCE b) ume 5 Rest ORK? YES 2	clav es. itus ven in Pari emia RTAIN [dence 6	icle, sc	AUTOPSY MED?	24b.	Weeks. Weeks. Wears. Were Autopsy finding Amailable Philor To Completion of Cause of Death? 1 Yes 2 No
IPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thei initiated events resulting in death) LAST PART II. Other algnificant condit dehydration DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not 1 determined 29e. CERTIFIER (Check only) 1 CERTIFYING PH	DUE TO (OR Metasta: DUE TO (OR L4 Verto DUE TO (OR Uncontro d. Uncontro d. Uncontro Cachexia NTRIBUTE TO CAUSI HOSPITAL: 1 Ringetiem 2 = ENJ (Month, Dey. Ye. 28e. PLACE OF INJU Building, etc. (YSICIAN: To the best of my key)	AS A CONSE tic C AS A CONSE ebrae AS A CONSE Olle olle	Cancer QUENCE OF): Cancer QUENCE OF): Cancer Canc	to r and etes e underlyi hype: NO[heck only one HER: Nursing Ho 1	left d kne mell ng cause giv rcalco UNCE) UNCE) HOUSE 2 Itee	clav es. itus ven in Pari emia RTAIN [286	icle, sc i. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) d. DESCRIBE HOW II LOCATION (Street or City or Town, State)	AUTOPSY IMED? NO NO NJURY OCCURRED Number es state	24b.	Months Weeks. Years. Were Autopsy Finding AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 No
IPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thei initiated events resulting in death) LAST PART II. Other algnificant condit dehydration DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not 1 determined 29e. CERTIFIER (Check only) 1 CERTIFYING PH	DUE TO (OR Metasta: DUE TO (OR L4 Verte DUE TO (OR Uncontre d. Uncontre d. MOSPITAL: 1 N Inpetient 2 ERL MOSPITAL: 1 N Inpetient 2 ERL 280. DATE OF INJU Month, Day, Ye 280. PLACE OF INJU Month, Day, Ye VSICIAN: To the best of my ke VSICIAN: To the best of my ke NINER: On the based of examin	AS A CONSE tic C AS A CONSE ebrae AS A CONSE Olle olle	Cancer QUENCE OF): Cancer QUENCE OF): Cancer Canc	to r and etes e underlyi hype: NO[heck only one HER: Nursing Ho 1	left d kne mell ng cause glv rCalco UNCE) U	clav es. itus ven in Pari emia RTAIN [286	iCle, SC II. 24a. WAS AN PERFOR 1 VES 2 Other (Specify) d. DESCRIBE HOW II LOCATION (Street a City or Town, State) te cause(e) end man, date end place, en	AUTOPSY IMED? NO NJURY OCCURRED Number os stated didue to the	24b. CURED or Rural F	Months Weeks. Years. Were Autopsy Finding AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 No
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condit Chydration DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not 1 determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINERY MEDICAL EXAMINERY	DUE TO (OR Metasta: DUE TO (OR L4 Verte DUE TO (OR Uncontre d. DUE TO (OR Uncontre d. JUNCONTRE JUNC	AS A CONSE tic C AS A CONSE ebrae AS A CONSE olle	Cancer Quence of: Quen	to r and etes e underlyi hype: NO[heck only one HER: Nursing He 28c. If M 1 , factory, off	left d kne mell ng cause giv rcalc UNCE b) um 5 Resi NUNCY NORK? YES 2 ice te end piece, e death occured 29c. Licen D128	clav es. itus ven in Pari emia RTAIN [dence 6 286 NO 286 and due to 9 d at the time SE NUMBER 384	iCle, SC LI. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW II City or Town, State) to cause(e) end man, date end piece, en	AUTOPSY MED? NJURY OCC and Number oner es state d due to the 29d, DATE	24b. CURED or Rural F ed. e cause(a	Months Weeks. Weeks.



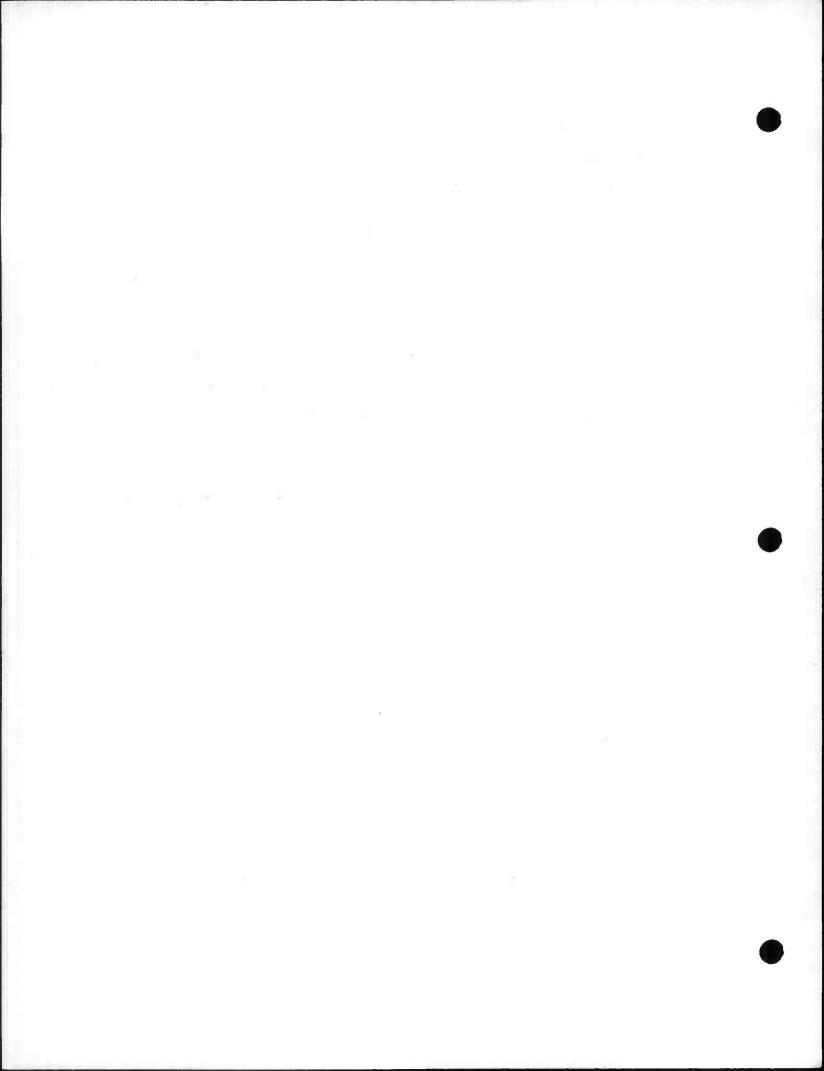
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN		
	Lloyd Wyker					Sept 30	1995	1:50pm M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. B	IRTHPLACE (State or Foreign		
	213-38-9653	1 [km 2 [F 8]	YRS.	MONTHS DAYS	HOURS MIN.	Apr 3 1914 Country) Apr 3 1914 Pennsylv				
_	9e. FACILITY NAME (If not institution, give a			9b. CITY, TOWN (OR LOCATION OF D	EATN	9c. COUNTY			
DIRECTOR	Calvert Manor 1	Healthcare Ce	enter	Risin	g Sun		Ceci	1		
EC	10a. STATE 10b. COUNT	TOWN OR LOCAT	HON			10d. INSIDE CITY				
DIR	MD Ce	cil		rth East				LIMITS?		
	10e. STREET AND NUMBER		110		ZIP CODE		10g, CITIZEN	1 YES 2 NO		
FUNERAL	53 CrossKeys Rd				21901		USA			
S	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify)	fee or No- 14. F	RACE — American Indien,		
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES GIVE WAR OR DATES			ectfy Cuban, Mexica 2 NO Specif	nn, Puerto Ricen, etc.)		Black, White, etc.		
		<u> </u>					wh	ite		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S L (Give kind of we life. Do NOT use	ork done durina mo	on st of working	16b, KIND OF B	USINESS/INDUSTF	TY .		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		Carrier		Danna	l C			
₩ O	17. FATHER'S NAME (First, Middle, Last)		Mail	carrier	18 MOTHER'S NA	POSTA.	L Servic	e		
	Alvin Wyker					lice Shad				
BE (19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or R		s)		
5	Ralph England					otsylvania		553		
	20a, METNOD OF DISPOSITION 1 Devial 2 Cremation 3 Rem	206	PLACE AND DATE OF	EDISPOSITION (No	me of	DATE 200 I	OCATION — City of			
	4 Donation 5 Other (Specify)	F	riends C	emetery	Oct 4 19	995 Ca	alvert M	D		
	21. SIGNATURE OF FUNEDAL SERVICE LIC	ENSEE	ID ADDRESS OF FA	CILITY	7.4					
	Kieland	X. (13			uneral Hor t Rising S		1011		
	23. PART I. Enter the diseases, or	piratory arrest,	Approximata							
	IMMEDIATE CAUSE (Final	List only one couse on e	ach line.					Interval Between Onset and Death		
	disease or condition resulting in death) a. Long Caneur DUE TO (OFF AS A CONSEQUENCE OF):									
NO	Sequentially list conditions, Due TO (OR AS A CONSCOUENCE OF):									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING									
임	CAUSE (Disease or Injury that Initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF	:						
E	resulting in death) LAST	4						İ		
	PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
SAL	PART II. Other aigniticant condition	e contributing to death b	ut not resulting in	the underlying	cause given in	Part I. 24a. WAS A	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ğ						1 YES	26 No	COMPLETION OF CAUSE OF DEATH?		
Σ	DID TOPACCO LICE CONTE	DIDLITE TO CALICE O	F DE ATHL ME					1 TYES 2 THO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI		F DEATH YES		UNCERTAIN	N 🗆]				
Sici	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	Thomas					
Ή	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c, INJU		6 Other (Specify) 28d. DESCRIBE HOW	IN ILION OCCUPER			
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJU	RY WO			INDOM GOOGNES			
	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY building, etc. (Spec	- At home, larm, str	eet, factory, office		281. LOCATION (Stree	and Number or Ru	ral Route Number,		
COMPLETED	4 Homicide detarmined	bulleting, etc. (Spec	пу			City or Town, Stat	0)			
P	29a. CERTIFIER (Check only	CIAN: To the best of my knowl	edga, death occurred	at the time, date	and place, and due	to the cause(a) and m	enner as stated.			
S O		R: On the besis of exemination						se(a) and manner as steted.		
	296. SIGNATURE AND TITLE OF BEST IFIER			T	29c. LICENSE NUM			NED (Month, Day, Year)		
BE C	7400				D443		D 10	2/65		
2	30. HAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, F	Print)	0110	13	10/	0/17		
	Joseph Widner M) 101 Colonia	1 Way Ri	sing Sur	219	11				
	31. DATE FILED (Month Day, Year) 100	101 Colonia 32. REGISTRAR'S SIGNA 5 Julia d'Aurel	ATURE P	8 344						
	0912 - 199	J Java diwell	ion nordall							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

MARY M. WHITE 4. SOCAL SECURITY NUMBER 4. SOCAL SECURITY NUMBER 5. SEX. 5. SEX. 6. AGE (in yr. last zurmdory) 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. WYS. 8. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OF ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR ORDITY 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION 9. COLVY, TOWN OR LOCATION OR LOCATION 9. COLVY, TOWN OR LOCATION 9. CO	35 P.M.M.
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220-01-2587	(State or Foreign
See PROCLITY NAME (From finalitation, pive almost and numbers) See CITY, TOWN OR LOCATION F SEATH SECONDARY See COUNTY OF DEATH PILTS VILLE SEATHER FOR COUNTY OF DEATH SECONDARY 100. STREET AND NUMBER 343.23 Main Street 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 11 NAMPLE TATUE STATUS 12 NAS DECEMBERT BENCHMONE 33 DECEMBERT BOUNDARY SEASON Speech; Second Status 13 NAS DECEMBERT STATUS 14 NAME (First, Models, Last) 12 NAS DECEMBERT BOUNDARY SEASON Speech; Second Status 15 NAME (First, Models, Last) 17 FATHERTS NAME (First, Models, Last) 18 NOTHERTS NAME (First, Models, Last) 19 NAME (First, Models, Last) 10 No. STREET STATUS 10 No. STREET STATUS 10 No. STREET STATUS 11 NAMPLE AND STATUS 12 NAME OF SEASON Speech; Second Status 11 NAMPLE AND STATUS 12 NAME (First, Models, Last) 12 NAME STATUS 12 NAME (First, Models, Last) 12 NAME STATUS 13 NAME (First, Models, Last) 14 NAMPLE AND STATUS 15 NAME AND STATUS 15 NAME AND STATUS 16 NOTHERTS NAME (First, Models, Maleino Sample) 16 NAME STATE STATUS 17 NAME STATUS 18 NAME STATUS 18 NAME STATUS 18 NAME STATUS 18 NAME STATUS 18 NAME STATUS 18 NAME STATUS 19 NAME STATUS 19 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 11 NAME AND STATUS 11 NAME AND STATUS 11 NAME AND STATUS 11 NAME AND STATUS 11 NAME AND STATUS 11 NAME AND STATUS 11 NAME STATUS 11 NAME STATUS 11 NAME STATUS 11 NAME STATUS 12 NAME STATUS 12 NAME STATUS 12 NAME STATUS 13 NAME STATUS 14 NAME STATUS 15 NAME STATUS 16 NAME STATUS 17 NAME STATUS 17 NAME STATUS 18 NAME STATUS 19 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NAME STATUS 10 NA	and
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10. STREET AND NUMBER 34 34 23 Main Street 11. MARIAL STATUS 11. MARIAL STATUS 11. MARIAL STATUS 11. MARIAL STATUS 12. WAS DECEDENT SUBJAN. DOCUMENTO PROPERTY (Speetly Year or No—Proncess)— 17 Yes 32 No Secondly. 13. SREEDEDST'S EDUCATION 14. RACE—And Status (Speetly Year or No—Second). 15. DREEDENT'S EDUCATION 16. RACE—And Status (Speetly Year or No—Second). 16. RACE—And Status (Speetly Year or No—Second). 17. Yes 3 No Secondy. 18. DECEDENT'S USUAL DOCUMENTON 18. MOTHER'S AME (Speetly Year or No—Second). 18. MOTHER'S NAME (Speetly Year or No—Second). 18. MOTHER'S NAME (Speetly Year or No—Second). 18. MOTHER'S NAME (Speetly Year or No—Second). 18. MOTHER'S NAME (Speetly MARIAGE, Makidan Dames). 18. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 18. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 18. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan). 19. MOTHER'S NAME (Speetly Makidan, Makidan). 19. MOTHER'S NAME (Speetly Makidan, Makidan). 19. MOTHER'S NAME (Speetly Makidan, Makidan). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames). 19. MOTHER'S NAME (Speetly Makidan, Makidan, Dames, Speetly Makidan, Makidan, Dames	INSIDE CITY
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19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Rurs. Steet. Zip Code) Shirley Taylor 20b. METHOD OF DISPOSITION 1 Select 2 Commission 3 Code Removal from State 4 Denation 5 Driller (Specify) 21. SIGNATURE OF DISPOSITION (Nume of Commission Commissio	
Shirley Taylor 7300 Pine St., Pittsville, Md.21874 20. METHOD OF DISPOSITION 1	
28. MSC AGASE REFERRED TO MEDICAL 28. MSC AGASE REFERRED TO MEDICAL 28. MSC AGASE REFERRED TO MEDICAL 28. MSC AGASE REFERRED TO MEDICAL 28. MSC AGASE REFERRED TO MEDICAL 28. PLACE OF INJURY 1 More of the control of the cont	
Pittsville Cemetery 9/27 Pittsville,	
21. SIGNATURE OF PURIERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bounds Funeral Home, Salisbur 23. PART I. Enter the diseases, or camplications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): LI VET - And gostro Tutus final states or conditions. The substitute of the causes. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. O	
23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory street, abovek, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A COMBRUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significant conditions contributing to death but not resulting	Mu.
23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory street, abovek, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Liver - and gastin Julyshmass Julyshmas	rv. Md.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpeliant 3 DOA 4 Nursing Home 5 Naeldence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28. PLACE OF INJURY At home farm street factory office 28. PLACE OF INJURY At home farm street factory office 28. PLACE OF INJURY At home farm street factory office 28. PLACE OF INJURY At home farm street factory office 28. PLACE OF INJURY At home farm street factory office 28. PLACE OF INJURY At home farm street factory office	Interval Between Onset and Death E AUTOPSY FINDINGS ABLE PRIOR TO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PAO 26. PLACE OF OEATH (Check only one) OTHER: 1 OTHER: 1 Inpetient 2 ER/Outpellent 3 DA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Neturel 5 Pending Investigation 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. PLACE OF INJURY At home farm street factory office.	PLETION OF CAUSE EATH? YES 2 NO
27. MANNER OF DEATH 288. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY AT WORK? 1 Notural 5 Pending Investigation 2 Accident Investigation 288. DATE OF INJURY (Month, Day, Year) 289. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? 1 Yes 2 NO 280. DATE OF INJURY OCCURED 280. DATE OF INJURY OCCURED 281. DOCATION (Street and Number of Burel Review of Burel Review)	
27. MANNER OF DEATH 286. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY AT WORK? M 1 YES 2 NO 286. DATE OF INJURY OCCURED (Month, Day, Year) 286. NAME OF INJURY AT WORK? M 1 YES 2 NO 286. DATE OF INJURY OCCURED (Month, Day, Year) 287. DATE OF INJURY AT WORK? M 1 YES 2 NO 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year) 288. DATE OF INJURY OCCURED (Month, Day, Year)	
Neutral	
1 268 PLACE OF INJURY At home, ferm street fectory office 1 281 LOCATION /Street and Number of Rural Route N	
4 Homicide determined	
29s. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and representations.	Yumber,
29c. LICENSE NUMBER 29d. DATE SIGNED (Month	
State Chart febru MA D 2509/ > 9/26/	menner as stated.
KOTALCHANDRASE KHIPA 306 KAYAVE SALISBURY MU 21801.	menner as stated.
31. DATE FILED (Month, Day, Year) SFP 26 1005 SEP 26 1005 SEP 26 1005 SEP 26 1005	menner as stated.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit nermit pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30. NAME AND ADDRESS OF PERSON WHO AND ADDRESS OF PERSON WHO ADDRE

ELMS STUET

32 REGISTRAR'S SIGNATURE

June d'audion handel

							50	3 3 6	
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY Y	3. TIME OF DEATH	
	Bessie Eva Holb					09 1	7 199		M
	The state of the s	. SEX 6. AGE (In	1 yrs. lest birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	_	BIRTHPLACE (Stete or Foreign Country)	
	9a. FACILITY NAME (If not institution, give etreet	t and number)	- 02	9b. CITY TOWN (OR LOCATION OF E	08/28/191		Maryland Y OF DEATN	_
DIRECTOR	28448 Venton Road			Princess				erset	
EC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY	
PIG -	Maryland Somer:	set	Pr	incess A				LIMITS?	
FUNERAL	28448 Venton Road			101	21853		10g. CITIZEI	N OF WHAT COUNTRY?	
5		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	ANIC ORIGIN? (Specify Ye		. RACE — American Indian, Black, White, atc.	_
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 X NO Spec	ean, Puerte Rican, atc.)		Specify:	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION npleted)	18e. DECEDENT'S	USUAL OCCUPATION of done during more retired.)	ON est of working	16b. KIND OF BU		frican America	an
APLE	9th grade	College (1-4 or 5+)	labore			Campbe	all Sour	. Inc	
Ö	17. FATHER'S NAME (First, Middle, Last)				18, MOTHER'S N	AME (First, Middle, Maiden	Surname)	1, 101	_
BE	Elijah D. Holbrook	, Sr.			Gert	rude E. Tuc	ker		
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	and Number or Rural	Route Number, City or Tow	n, Stete, Zip Co	ide)	
	Rev. Otho R. Waters		same a	s above					
	20e. METHOD OF DISPOSITION 1 K Burlal 2 Cremation 3 Removal 4 Donation 6 Other (Specify)			ther place)				nne, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	#	JCE 0.141.	22. NAME AN	O ADDRESS OF F	ACILITY Jolley A	dess A	nne, Maryland	
	* altrein	P. Folle	y	11213 J	ersey Ro	pad – Salisbu	iry, MC	21801	
	23. PART I. Enter the diseases, or com shock, or heart failure. List	plications that caused	the leath. Do n	ot enter the mo	de of dylng, su	ch as cerdlec or resp	iratory arrest	Approximate interval Between	
	IMMEDIATE CAUSE (Final		- 12					Onset and Dear	
	disease or condition resulting in death)	KE SPIRE		MILLIEE				8 mounts	
		DUE TO (OR AS A C		F):	STAG	_		0.	
O	Sequentially list conditions, b	DUE TO (OR AS A C		+ENO	2144	6		2-te Aag	
Ä	if any, leading to immediate cause. Enter UNDERLYING	,	12.2.	,				j	
FF	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	ŋ:					-
ERTIFICATION	resulting in death) LAST								
C	PART II. Other significant conditions of	ontributing to death bu	t not resulting i	n the underlying	cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
2	CONGESTIVE H	The same of the sa	HLURE			PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
						1 □ YES 2	NO.	OF DEATH?	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S NO C	UNCERTAI	N 🗆		1 1 123 2 1 10	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF DEAT						
YSI	1 YES 2 NO 1	☐ Inpetient 2 ☐ ER/Outpet	tient 3 🗆 DOA	OTHER: 4 Nursing Nom	5 X Residence	6 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIMI		URY AT AK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED	
BY	2 Accident Investigation				ES 2 NO				
TED	3 Suicide a Could not be 4 Nomicide determined	28s. PLACE OF INJURY - building, etc. (Specif)	– A1 home, farm, a	rtreet, factory, office		28f. LOCATION (Street a City or Town, State)	and Number or i	Route Number,	
J.	290. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowled	doe, death occurre	d at the time date	and place, and di-	a to the powerful and are			\dashv
COMPLET								euse(s) end menner es atated.	
E C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IGNED (Month, Day, Year)	-
0	alwan (bran	MV		044	061		20 (S	
유	30. NAME AND ADDRESS OF PERSON WHO CO		TH (ITEM 27) (Type,		- / / /			V0[52	\dashv
	TLZ 12/13/7	ELMS S	THAT	PRINCE	SS ANNE	E MD	2185	3	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT			, ,,,,,,		2-02		٦

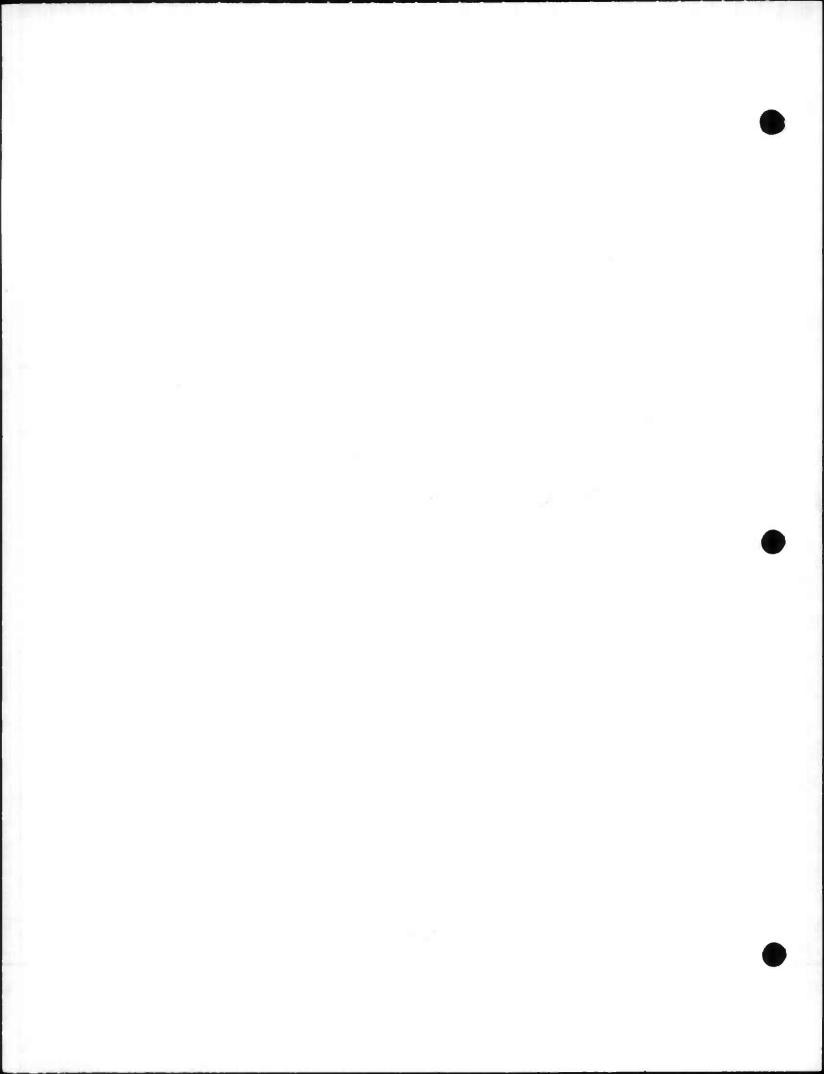
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MICHAFL R. ATKINS
31. DATE FILED SEP 20 1995

40SPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit Panes 1 2 3 should	be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cemation, or removal.	MPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL	THE FUNE	filed within	PORTANT
2	2	2	Ξ

	WEBSTER, OLA									C	5	31317
	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAF ERTIF	RTMENT	OF HE	ALTH DEAT	AND I	MENTAL HYGII	ENE		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	DAV	VEAG	3. TIME OF DEATH
	OLA MAI	5. SEX	WEBSTER						SEPTEMBE	Ŕ 17,	1995	3.45 D M
	A TOTAL TOTAL CONTROL	IF UNDER	_	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year,		8. BIRTH Countr	IPLACE (State or Foreign			
	2 18-48-58 16 1 M 2 R F 10 1 YRS. MONTHS DAYS HOURS MIN. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF D								May 4, 189			yland
œ							ATH		UNTY OF D			
16	SALISBURY NURS	ING &	REHAB.C	TR.	SF	LIS	BUR	Y		W	COM:	ICO
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	R LOCATIO	ON					10d. INSIDE CITY
		comico			Salis	bury						LIMITS?
FUNERAL	10a. STREET AND NUMBER						ZIP CODE			10g. Cl		VHAT COUNTRY?
Ä	Springhill Rd.						2 180	1			USA	
E	11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or N If yee, specify Cuban, Maxican, Puerto Rican, atc.)							Yes or No-	14. RACE	- American Indian, c, White, stc.		
B	3 ★ Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 ★ NO Specify:								Spec/	'.		
8	15. DECEDENT'S EDUCA		16a, DE0	CEDENT'S	USUAL O	CUPATION			18b. KIND OF	NISINESS/IN		ite
ETED	(Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 8	Ma	ve kind of Do NOT u	work done one retired.)	during most	of working	g				
¥	7			omema	aker							
COMPL	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Malden Surname)											
BE	Robert M. Ross Laura Catherine Williams								ms			
9	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	Pearl W. Furniss							e.,	Salisbur	y,MD	21801	
	20a. METHOD OF DISPOSITION 1 ☑ Burlet 2 □ Cremation 3 □ Remov	mi from State	20b. PLACE A cemetery, crem	natory or o	ther place)				DATE 20c.			
5	4 Donation 8 Other (60004)	wass //	Pars	ons	Ceme	tery			9/21 S	alisb	ury,	MD
TO BE COM	11. 1111	11/.//	7			Holl			neral Hom	e		
	Whok. S	Kello	cecoo	1		501	Snow	Hil	ll Rd., S	alisb	ury,M	ID 21801
TIFICATION	23. PART I. Enter the diseases, or co shock, or heart failure. Li	implications the	t caused the de	Do r	ot anter	the mode	of dyle	ng, such	as cardiac or re	piratory a	rreat,	Approximate
	IMMEDIATE CAUSE (Final			1					h			Interval Batween Onset and Death
	disease or condition resulting in death)	Co	OR AS A CONSEO	372	ZWO	0	De	nel	is			mony yes
		DUE TO	(OR AS A CONSEO	UENCE O	F):	0						
RTIFICATION	Sequentially list conditions, b.	OUE TO	(OR AS A CONSEO	HENCE O								
¥.	If any, laading to immediata cause. Enter UNDERLYING	302 10	(OII AS A CONSEC	OENCE O	<i>;</i>							
문	CAUSE (Disease or Injury that Initiated events	DUE TO	(OR AS A CONSEQ	UENCE O	F):					-		
E	resulting in death) LAST											
Ö	PADT II Other elegificant conditions		death but the									
MEDICAL	PART II. Other algnificant conditions	Ano	daath but not re	auiting	in the un	derlying	cause gi	iven in i		AN AUTOPSY ORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	ASCU	0	1/50/						1 _ YES	2 NO		OF DEATH?
MEDICAL CI			HICE OF DEAT	FI 1 1/F	·	10.100	111100					1 YES 2 NO
N N	DID TOBACCO USE CONTRI	BUIE IO CA			H (Check o		UNC	RIAIN				
SICI/	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER	:	YESON.		_83 = 210			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b, TIM	· v	ing Home 28c. INJUR		ildence (Other (Specify) 28d, DESCRIBE HOY	V INJUSTY OC	CUBEO	
ВУ Р	1 Natural 5 Pending	(Month, D	ay, Year)	INJ	URY	WORK	67 8 2 □	NO			- CONLEG	
	3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At hor	ne, farm, s	treet, facto	ry, office			281. LOCATION (Street		r or Rural R	oute Number,
	4 Homicide determined	ounding,	atc. (Specify)						City or Town, Sta	te)		
COMPLETED	29a. CERTIFIER (Check only	AN: To the best of	my knowledge, des	th occurr	d at the fli	ne, data ar	nd place.	and due 1	to the cause(s) and n	enner en ets	ted.	
NO OM												and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER							YSE NUM				(Month, Day/Year)
	w	0	mo			- 10	D-39			DA. DA		18/9V
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) (Туре,	Print)			313				- [

M.D., 1104 HEALTHWAY DR., SALISBURY, MD
32 REGISTRATS SCHATURE
Julia Charles Schature



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

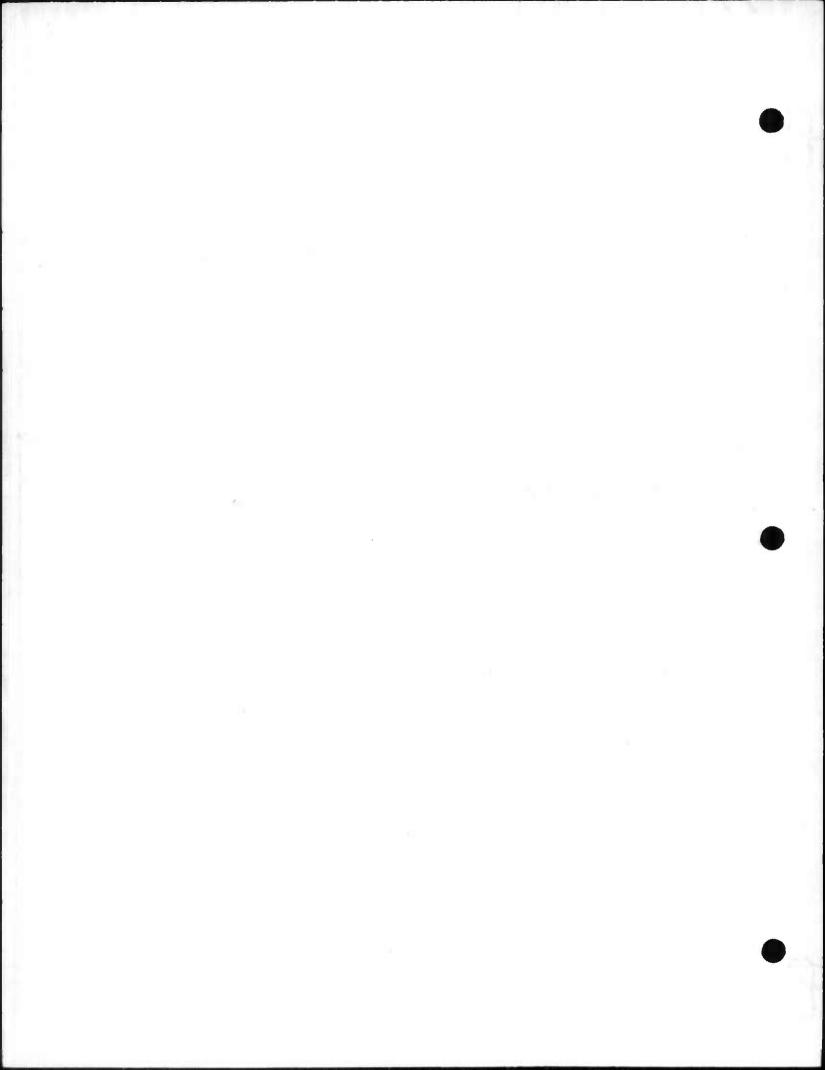
FOR STATE

TO BE COMPLETED BY FUNERAL DIRECTOR

REGISTRAR		CERTIFIC	ATE O	F DEATH	RE	EG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)	William	E. Wald	ron		2. DATE OF D MONTH Sept.		995°	3. TIME OF DEATH 8:58 P M
4. SOCIAL SECURITY NUMBER 5.			UNDER 1 YEA		7. DATE OF BI (Month, Day)		8. BIRTI Count	HPLACE (State or Foreign
220-34-9680	M 2 F	56 YRS.	NTHS DAY	S HOURS MIN.	09/2	1/38		yland
9a. FACILITY NAME (If not institution, give street	· ·		CITY, TOW	N OR LOCATION OF DE	ATH	9c. C	OUNTY OF E	DEATH
Memorial Hospit	cal at Eas	ston	Εa	ston		Т	albo	t
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c. CITY, TO	OWN OR LO	CATION				10d, INSIDE CITY
	nester			Hu	rlock			LIMITS? 1X YES 2 NO
10e. STREET AND NUMBER				10f. ZIP CODE				WHAT COUNTRY?
4013 Bradley Ci				216				States
11. MARITAL STATUS 12 15 Never Married 2 Married	. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	If yes	DECENDENT OF HISPAN , specify Cuban, Maxico	in, Puarto Rican,		Blac	E — American Indian, ik, Whita, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	10	YES ZX NO Specif	y:		Spec	White
15. DECEDENT'S EDUCATI (Specify only highest grade com		16a. DECEDENT'S USI	JAL OCCUP	ATION	16b. KINI	D OF BUSINESS	INDUSTRY	
	college (1-4 or 5 +)	life. Do NOT use re	tired.)	most or working	_			100
12th		Journ	eyma	n	P	ublish	ing	
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA			1	
	A. Waldı					Blade		
19a. INFORMANT'S NAME (Type/Print) Mary Alice Bliz	zard			set and Number or Rural Secretar				
20a. METHOD OF DISPOSITION		PLACE AND DATE OF E		(Name of	DATE	29c. LOCATION	- City or T	own, State
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	From State Cem	netery, cremetory or other astern Si	nore	Veteran	s 18	Hur1o	ck,	Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			E AND ADDRESS OF FA		Fokow	Fun	eral Home
Muchael 7.	Esken			Box 43,				
23. PART I. Enter the diseases, or com shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)		ach line.		cerelizer				Approximate interval Between Onset and Daeth
Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		CONSEQUENCE OF):				- 70		
resulting in death) LAST								
PART II. Other aignificant conditions of	ontributing to death b	out not resulting in I	he under	ying ceuse given in	Part i. 24a	. WAS AN AUTOP	SY 24	b. WERE AUTOPSY FINDINGS
De00 10 1000	tus timo	-1 /. 1 1		megun		PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
1. Po Inultino	6010000	X - 60 cd	405	A S	O lail	.0		DF DEATH?
DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	NO	UNCERTAI	AT -	and.		1 120 1 10 10
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	Check only	one)				
	OSPITAL: Ainpatient 2 - ER/Outs		THER:	Home 5 - Residence	6 Other (Sp	ecity)		
27. MANNER OF DEATH Naturel 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME C	9F 28c	INJURY AT WORK?		BE HOW INJURY	OCCURED	
2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY building, etc. (Soe	— At home, farm, stre			281. LOCATION	N (Street and Nur	mber or Rural	Route Number,
4 Homicide determined	Sensing the topo				Oily or ion	wii, otaley		
(1/Hele only	N: To the best of my know On the besis of axeminatio				•			(a) and manner as stated.
290. SIGNATINE AND TITLE OF CERTIFIER			1	29c. LICENSE NU	MBER	29d.	DATE SIGNE	D (Month, Day, Year)
Journa	D.50	ticen.	W	D272	t09	Þ.C	7-18	3.95
	ompleted cause of de		,	an's T.n	. Fact	ton M	ח 2 1	6.0.1
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE	CIIII	an n nii.	, Las	COII, M	. V L I	001
SEP 1 9 '95	yuna Davidson	n-Randall						

Pages 1, 2, 3 should

										JU	O.	1017
_	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMENT ICATE	OF HE	ALTH A	AND M	ENTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Lest) Phyllis Irmga	rd Wet:	zel					- 1	2. DATE OF DEATH DO NONTH DO NONTH DO		YEAR	7:34 PM
	4. SOCIAL SECURITY NUMBER 218-24-7755	5. SEX 1 M 2 X F	6. AGE (in yrs. le: 67	st birthday) YRS.	IF UNDER		IF UNDER 24	4 HRS.	Jan 14,19	28	Country)	vland
_	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY,	TOWN OR		OF DEA		9c. COUNT		
DE S	Frederick Memori	al Hospit	al			Fred	eric	k		F	rede	rick
DIRECTOR		rederick		10c. CIT	Fred	eric					- 1	IOd. INSIDE CITY LIMITS? I YES 2 NO
FUNERAL	1605 Colonial Wa	у				101. 2	217	02			S.A	AT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	NO	11	VAS DECEM Yes, spec	ify Cuban,	Mexican,	ORIGIN? (Specify Yes Puerto Rican, atc.)	or No- 1	Black,	- American Indian, Whita, etc. White
TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	live kind of	USUAL OC	CUPATION furing most	of working		16b. KIND OF BUS	INESS/INDU	STRY	
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare/Hospital 17. FATHER'S NAME (First, Middle, List)								ital			
Usher Josian Eilek Mary Catharine KUMP								P				
2										1703		
	20a, METHOD OF DISPOSITION 1	SPOSITION remetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Capacity,								n State		
	PMC. Offiver Cemetery Oct 4,1995 Frederick, Maryland 22. NAME AND AGGRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701								me			
CERTIFICATION	23. PART I. Enter the diseases, or ahock, or heer failure. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. VEM DUE TO OUE TO C.	RKULI	OUENCE OF	AS DR. L	4510	DLE		ACRO-PO			Approximate Interval Between Onset and Death ZO MIN
PHYSICIAN: MEDICAL	PART II. Other algnificent condition CISARette S	ma contributing to	deeth but not r	resulting	in the unc	derlying o	cause giv	ven in Pa	PERFOR 1 YES 2	MED?	a d	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
AN:	DID TOBACCO USE CONT	RIBUTE TO CA			S N		UNCE	RTAIN	Ø			
SICI	EXAMINER?	HOSPITAL:			OTHER	:	5 Resid	dence 8	Other (Specify)			
	27. MANNER OF DEATH 1 Metural 5 Pending	28a. DATE OF (Month, Di	INJURY ny, Year)	28b. TIM		28c. INJUR WORK	Y AT	2	ed. DESCRIBE HOW IN	NURY OCCU	RED	
TED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — At ho	me, ferm, e	treet, facto			-	8f. LOCATION (Street a City or Town, State)	nd Number or	Rural Rou	ite Number,
COMPLETED									the cause(a) and men			nd menner as stated.
TO BE C	29b. SIGNATURE AND /TITLE OF CERTIFIES	7. Vitarel	6M.0			2	Da-	754	ER (4	29d. DATE 8	IGNED (A	fonth, Day, Year)
	John A. Vitarell	o. M.D.	310 Wes	st Ni	nth S	Stree	t, F	rede	erick, Mar	yland	217	01
	31. DATE FILED (MONTH, DX 14") 1995	32. REGISTRAI	AUCULION A	ardall	1							



BE COMPL

9

30. NAME AND ADDRESS OF PERSON WHO

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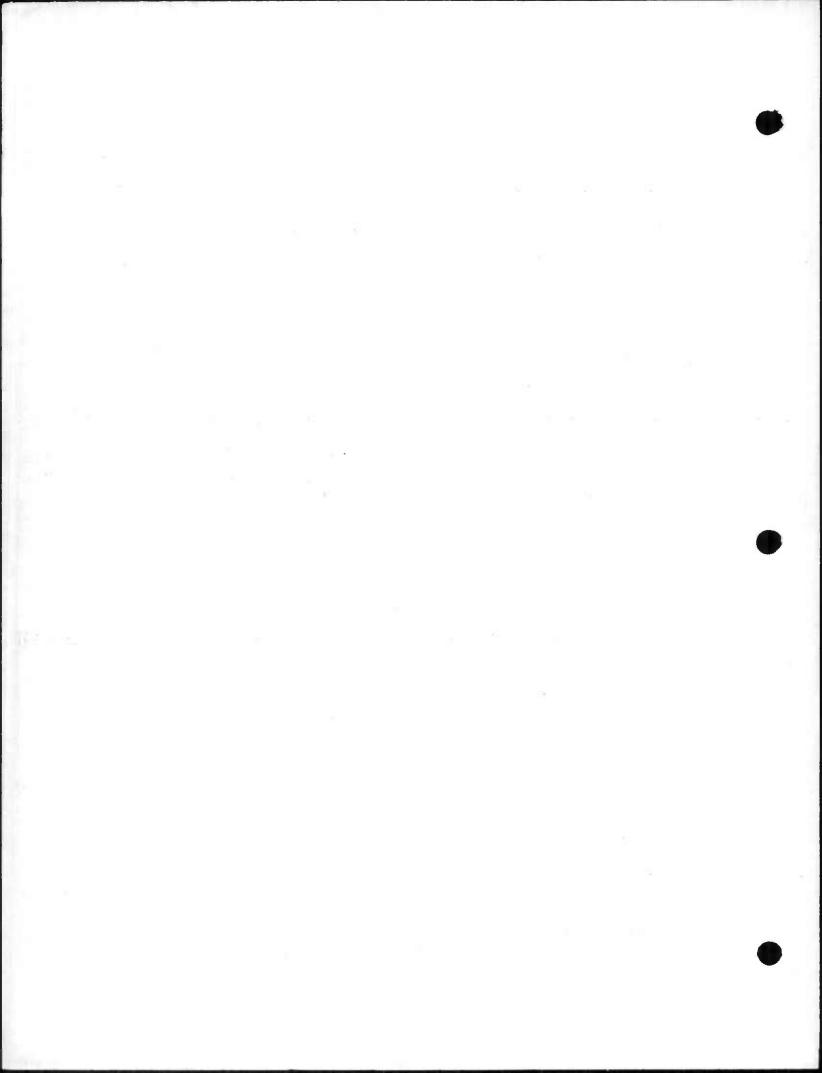
31. DATE FILED (Month)

							95	ن	1320
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM						
	1. DECEDENT'S NAME (First, Middle, Last)		OLITITIO!	AIL OI	DEATH	REG. NO		-	
	Thez		1	11/		2. DATE OF DEATH MONTH D	AY	YEAR	3. TIME OF DEATH
	1116 R.			uni	D	SEAT 2	7_/	995	0300 am
	and the second of the second o			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
	220-32-6851	□ M 2 😾 F 83	YRS. MON	THE DAYS	HOURS MIN.	Jan 22,1	912		ryland
	9a. FACILITY NAME (If not institution, give stree		96.	CITY, TOWN	OR LOCATION OF D		-	NTY OF DE	
DIRECTOR	Shady Grove Adv				cville		Montgomery		
ត្ត	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY								
<u>=</u>		gomery		WN OR LOC					10d, INSIDE CITY LIMITS?
		gomery	C1	arks	ourg				1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER			1	Of. ZIP CODE		10g. CITI	ZEN OF W	HAT COUNTRY?
后	23320 Clarksbu	rg Road			20871			U.S.	Α.
ΞI		2. WAS DECEDENT EVER IN U.S							
립	1 Never Married 2 Married	FORCES? 1 YES 2		13. WAS DE	CENDENT OF HISPAI pecify Cuban, Maxica	NIC ORIGIN? (Specify Yearn, Puerlo Rican, etc.)	or No-	14. RACE Black,	- American Indian, White, etc.
'n	32 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		S 2 NO Specif		- 1	Specify	y:	
									White
Ĭ I	15. DECEDENT'S EDUCAT (Specify only highest grade cor		DECEDENT'S USU	AL OCCUPAT	ION	16b. KIND OF BU	SINESS/IND	USTRY	
ᇤ		College (1-4 or 5+)	(Give kind of work life. Do NOT use ret	ired.)	lost or worlding				
리	12		Homemal	cer		Own	home	•	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				de Morrisono Ma	ME (First, Middle, Maiden			
								·	
BE	Ernest Balle	nger				llie Ma	4	inna	1
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			20871
-	Bonnie W. Coole	Y	23320	0 Cla	rksburg	Rd., C1	arks	burg	, Maryland
	20a. METHOD OF DISPOSITION	20b. PL/	ACE AND DATE OF DI	SPOSITION //	lame of	DATE 20c. LO	CATION -	City or Tow	en State
	Donation 8 ☐ Other (Specify)	Complet	y, crematory or other p						
	21. SIGNATURE OF FUNERAL SERVICE LICEN		irksburg		IECELY AND ADDRESS OF FA		arks	burg	,Maryland
		1	,				Dλ	Fur	neral Home
	- Ullia II	Motor To	ti,						
	23. PART I. Enter the diseases, or com	proceedings that severed the	death De set	2640	I Ridge	Road, Da	masc	us, r	
	ahock, or heart failure. Lis	t doly one ceuse on eech	line.	enter the m	ode of dying, suc	n se cerdiec or respi	ratory arr	est,	Approximats Interval Between
	IMMEDIATE CAUSE (Finel								Onset and/Death
- 1	disease or condition	massive	accito	C					12 coks
ł	resulting in death) s	DUE TO (OR AS A CO							2412
		congestive	h001-	10	Munn				110
CERTIFICATION	Sequentially list conditions, b	DUE TO (OR AS A COI	11eur	1 46	WIME.				10413
F	If any, leading to immediate cause, Enter UNDERLYING		NSEQUENCE OF):		Menan:				1/9
⊴ ∥	CAUSE (Disease or Injury	coronary	anter	y c	(1) SEUSE	2			10413
느	that initiated events	DUE TO (OR AS 4 CO				ent.			
	resulting in death) LAST	netartation	s ovari	an	ancini	oma			LUNKY OWN
ວ ∥									
4 1	PART II. Other significent conditions of	ontributing to deeth but n	ot reculting in th	e underlyle	ng cause given in	Part I. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	severe o	which st	enosis			1 _ YES 2	0 -9		COMPLETION OF CAUSE
입내	NYDONTOIN	sion				TO TES 2	NO NO	- 1	OF DEATH?
Σ				7	A				1 TES 2 NO
CIAN:	DID TOBACCO USE CONTRIB				UNCERTAIL	иШ			
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH (C)				
<u>ज</u> ॥	1 TES 2 NO	OSPITAL: Inpetient 2 - ER/Outpetier		HER: Nursing Ho	me 5 🗆 Residence	8 Other (Specify)			
PH PH	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME OF		JURY AT	28d. DESCRIBE HOW I	N.IIIPY OCC	TIBED	
	1 Natural 5 Pending	(Month, Day, Year)	YAULMI	W	ORK?	DECOMBE NOW I	JOH! OUC	JONES	
à l	2 Accident Investigation				YES 2 NO				
al	3 Suicide 8 Could not be	28e. PLACE OF INJURY A building, etc. (Specify)	it home, farm, street	, factory, offi	ca	281. LOCATION (Street a City or Town, State)	and Number	or Rural Ro	oute Number,
	4 Homicide detarmined					, , , , , , , , , , , , , , , , , , , ,			
A 19									

29d. DATE SIGNED (Month, Day, Your)

Soptombor 27 29c. UCENSE NUMBER 0 4/2/0 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Germantown

32. ARGISTRAS SIGNATURE
Saucher Randall



BALTIMORE, MARYLAND 21215-0020
A hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TID THE FINNERAL DIRECTIONS. Make this certificate has been circued by the death certificate and a necessary. DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

		NEGISTAAN			-Ittill I	OMIL (JE DEA	10	REG. NO	•		
		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH D		EAR 3.	TIME OF DEATH
		HELENE	McCORMICK	A	LLAN					3, 199		6:24P M
		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. la		IF UNDER 1 YE		24 HRS.	7. DATE OF BIRTH		BIRTHPLA	CE (State or Foreign
_		060-01-1458	1 🗆 M 2 💢 F	92	YRS.	MONTHS DA	WB HOURS	MIN.	NOV. 7, 190	2 N	EW Y	ORK
should		9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
C)	E E	GREATER BALTIMOR	E MEDICAL	CENTER					••••			
.2	١Ķ	RESIDENCE OF DECEDENT		02111111		10	WSON			BALT	IMOR	E
Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY,	TOWN OR L	OCATION				100	I. INSIDE CITY
~; &	<u></u>	MARYLAND BAL	TIMORE CIT	Y	BA	LTIMO	RE				16	LIMITS? YES 2 NO
permit.	A L	10e. STREET AND NUMBER					10f. ZIP CODE	E		10a. CITIZEI		COUNTRY?
	FUNERAL	3004 CLEARVIEW A	VENUE				212	234		U.S		
burial-transit	3	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AF	RMED	13 WAS	DECENDENT O	E HISDAN	IC ORIGIN? (Specify Yes	as No. 14	DACE	American Indian.
Darri Darri		1 Never Married 2 Married	FORCES? 1 IF YES, GIVE WAR	YES ZALA	NO	If ye	s, specify Cuba	n, Maxicar	t, Puerto Rican, etc.)	O NO -	Bleck, W	hite, stc.
il il	BY	3 X Widowed 4 Divorced	ii res, are inte	ON DATES		''	AES SX NO	Specify			Specity:	WHITE
es Se	8	15. DECEDENT'S EDU	ICATION	18a. DE	ECEDENT'S U	SUAL OCCU	PATION		16b. KIND OF BUS	SINESS/INDUS	TRY	
Tor use	ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G	litve kind of wo Do NOT use	DENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY kind of work done during most of working o NOT use retired.)						
9	7	12TH GRADE	contage (1-4 or 5+)	НО	MEMAK	ER			DOM	ESTIC		
once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16 MOTE	ACD'C MAI					
a 6												
should be detached tiffied at once.	BE	19a. INFORMANT'S NAME (Type/Print)				222222				-		
o snould	임	GEORGE KLEINMETE	R						COP, NEW Y			
pe an		20a. METHOD OF DISPOSITION		_				, עאנ			2473	
must		1 N Buriel 2 Cremetion 3 Rem	novat from State		AND DATE OF					CATION — City		
		4 Donation 5 Other (Specify)		HOLY	CROSS					OOKLYN	, NE	W YORK
d. examiner must		21. SIGNAL UNE DE PUNERAL SEMPLE LA	CENSEE	//		HIIR	RARD FI	INFR	AL HOME, I	NC.		
		Aires		A	las				VENUE-BAL'		MD	21229
oy une smoval.		23. PART I. Enter the diseases, or	complications that c	used the de	with. Do no	enter the	mode of dyl	no such	A VENUE-DAL	TITIONE	, PID	
or removal.		snock, or heart failure.	List only one cause	on each link						ratory arrest	,	Approximata interval Between
ion.		IMMEDIATE CAUSE (Final disease or condition	1	1	· - 0		201					Onset and Death
d, cremation, event, the		resulting in death)	a	e7 LJ	nav	01	ZW	Cl	con			12 days
			DUE TO (OF	AS A CONSE	OUENCE OF):	20	5)_	tom			12 days
Hygiene prior to bunic or other traumatic	CERTIFICATION	Sequentially list conditions,	a Can	cer	>	TW	2 '	ec.	Tum			o majeu
or to	F	if any, leading to immediate cause. Enter UNDERLYING	10) 01 300	AS A CONSE	DUENEU OF):							
er th	임	CAUSE (Disease or injury	C. DUE TO COR	AS A CONSE								
e de	Ē	that initiated eventa reaulting in death) LAST	JOE 10 (OF	AS A CONSE	DUENCE OF):						i	
tal H	浜		d									
th and Menta any Injury,		PART II. Other significant condition	ns contributing to de	ath but not r	asulting in	tha under	ving cause o	lven in F	Part I. 24a. WAS AN	AUTOPSV	24h WEI	RE AUTOPSY FINDINGS
and I	EDICAL						,,		PERFOR	MED?	AVA	ILABLE PRIOR TO
Health WS a									1 YES 2	XNO	OF	MPLETION OF CAUSE DEATN?
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State Dept. of I	PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUS				7	ERTAIN				
State	10	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEATN	(Check only o	one)					
00	YS	1 TYES 2 NO	1 Separtent 2 EF	VOutpatient 3			Nome 5 🗆 Re	sidence (Other (Specify)			
2 0	玉川	27. MANNER OF DEATN	28a. DATE OF INJ (Month, Day,		28b. TIME INJUI		INJURY AT WORK?		28d. DESCRIBE NOW IN	IJURY OCCUR	ED	
od, or	0. 1				1.00		YES 2	NO	-			
ath with the		1 Netural 5 Pending Investigation										
death with t	р ву	Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF IN	JURY — At ho	me, ferm, str	est, tectory,	office		281. LOCATION (Street a	nd Number or I	Rural Route	Number,
death with t	TED BY	Accident Investigation	28s. PLACE OF IN building, stc.	IJURY — At ho (Specify)	me, ferm, str	est, tectory,	office		28f. LOCATION (Street a City or Town, State)	nd Number or i	Rural Route	Number,
death with t	ETED BY	Accident Investigation Accident Accident	building, atc.	(Specify)			<u> </u>		City or Town, State)		Rural Route	Number,
72 hours after death with 1 If Item 28 is marked,	ETED BY	Accident 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	ICIAN: To the best of my	(Specify)	ath occurred	at the time,	data and place,		City or Town, State) to the cause(a) and man	ner as stated.		
72 hours after death with 1 If Item 28 is marked,	TED BY	Accident Accident Investigation	ICIAN: To the best of my	(Specify)	ath occurred	at the time,	data and place,		City or Town, State) to the cause(a) and man	ner as stated.		
72 hours after death with 1 If Item 28 is marked,	E COMPLETED BY	Accident 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	ICIAN: To the best of my	(Specify)	ath occurred	at the time,	data and place, on, death occur		City or Town, State) to the cause(a) and man ime, data and place, and	ner as stated.	euse(s) and	f manner as stated.
hours after death with 1 Item 28 is marked,	COMPLETED BY	Accident 3 Suicide 4 Nomicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER CLOCK 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my	knowledge, de	inth occurred investigation,	at the time,	data and place, on, death occur	ed at the t	City or Town, State) to the cause(a) and man ime, data and place, and	ner as stated.	suse(s) end	f manner as stated.
filed within 72 hours after death with 1 PORTANT: If Item 28 is marked,	BE COMPLETED BY	Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WIN	CIAN: To the best of my	knowledge, de	inth occurred investigation,	at the time,	data and place, on, death occur	ed at the t	City or Yown, State) to the cause(a) and man ime, data and place, and BER	ner as stated. d due to the co	guse(s) and	i manner as stated.
filed within 72 hours after death with 1 PORTANT: If Item 28 is marked,	BE COMPLETED BY	Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WN	ICIAN: To the best of my IR: On the basis of exam CO COMPLETED CAUSE O	knowledge, de ination and/or	inth occurred investigation,	in the time, in my opinion	data and place, on, death occur	ed at the t	City or Town, State) to the cause(a) and man ime, data and place, and	ner as stated. d due to the co	guse(s) and	f manner as stated.
filed within 72 hours after death with 1 PORTANT: If Item 28 is marked,	BE COMPLETED BY	Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WIN	CIAN: To the best of my	knowledge, de ination and/or	investigation,	in the time, in my opinion	data and place, on, death occur	ed at the t	City or Yown, State) to the cause(a) and man ime, data and place, and BER	ner as stated. d due to the co	guse(s) and	i manner as stated.

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detached for use as the burial-transit permit.

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296. SIGNATURE AN

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	N.	SE	ep	23
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 his	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, c	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the n
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH MATY E Albright 9:15 Am 10 BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH HOURS 212-05-8788 1 M 2 D F 91 May 9, YRS. 1904 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll Lutheran Village Westminster Carrol1 RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carrol1 Westminster 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 200 St. Luke Circle 21158 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 XWidowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Housewife own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Horace E. Triplett BE Burganettie Dell notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Thelma Schwatka 4329 Holbrook Road Randallstown, MD 21133 pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must wards Chapel Ch. Cemetery 10/17 Donation S Other (Specify) Randallstown, MD medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown Is given the diseases, or complications that caused the seath. Do not enter the mode of dying, such as cardisc or respiratory arrest, **Approximate** ock, or heart fellure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Schemic wast 1991 traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury other DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 10 UNCERTAIN 1 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINERS 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 8 □ Other (Specify) 9 27. MANNER OF DEATH 26a. DATE DF INJURY marked, 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Nature 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE DF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 95 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide determined Hem

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ation and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and menner as stated.

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29c. LICENSE NUMBER

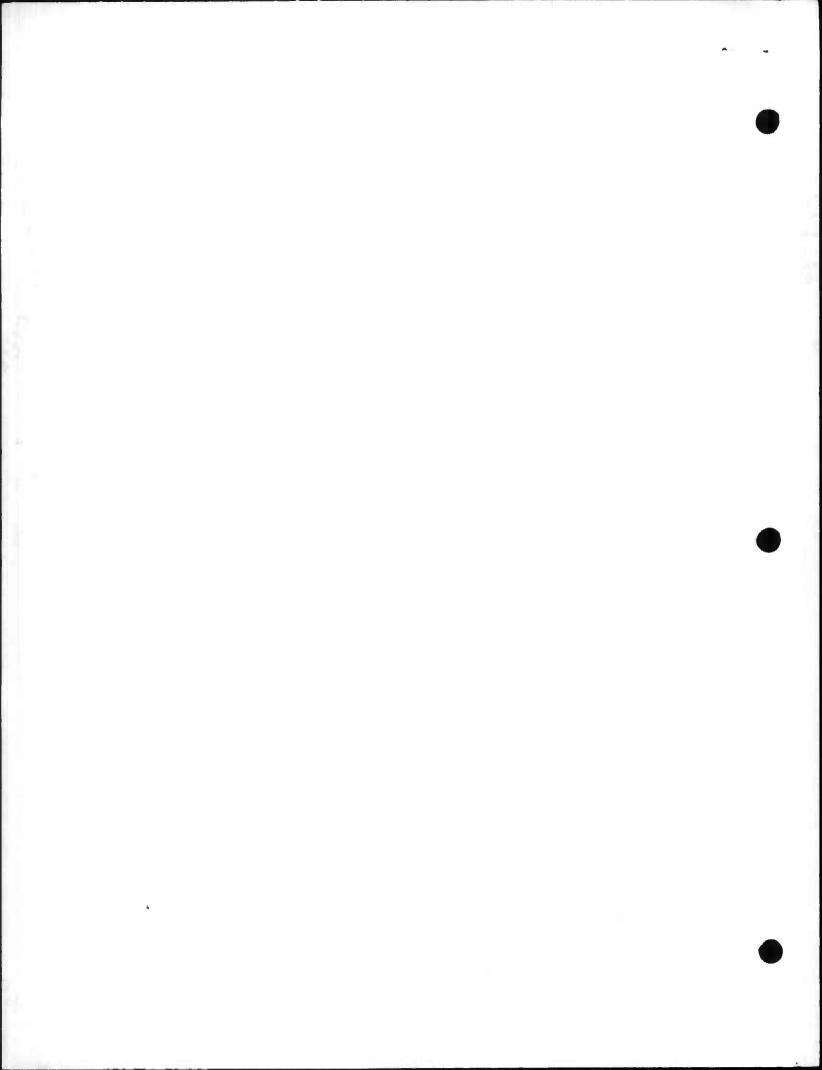
MER: On the bests

E.D

WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Typ

32 REGISTRAR'S SIGNATURE

DHMH-18 Ray 1/89



FOR STATE REGISTRAR

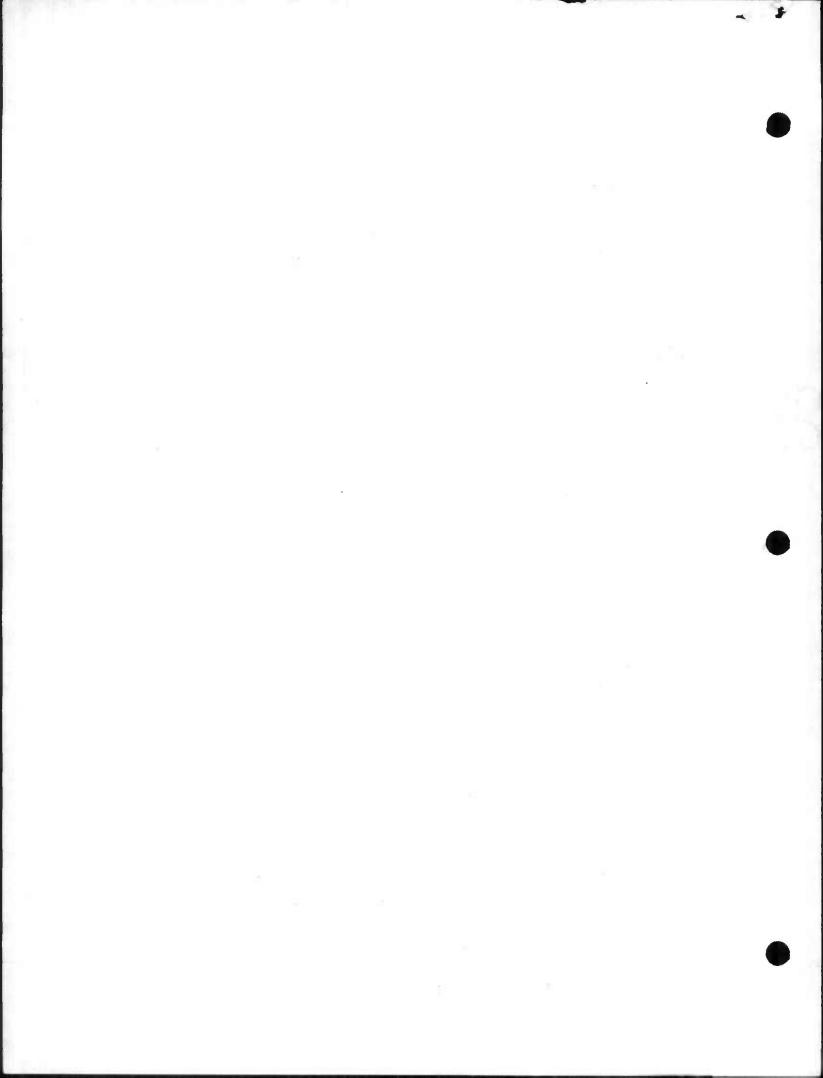
1. DECEDENT'S NAME (First, Middle, Last)

1 -

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY VEAR 2. DATE OF DEATH DAY VEAR OCT. 16. 1995										TIME OF DEATH	
DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last) IF UNDER 1 YEAR IF UNDER 24 HRS.			Oct. 16, 1995			LACE (State or Foreign
	000 04 1470 7			90	YRS.	MONTHS	Office the Control of the control of				Country)	inia
						9b. CITY,	TOWN 0	R LOCATION OF DE		9c. COUN		
	3931 McDonogh Road Randallstown Baltimore											
JIREC	10s. STATE Maryland					oc. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 YES 2 1 NO		
	10s. STREET AND NUMBER					RAIIGALISCOWII				10g. CITIZEN OF WHAT COUNTRY?		
ERAL	3931 McDonogh Road 21133 U.S.A.											
BY FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 ☐ Never Married 2 ☐ Merried 12. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American India Black, Whits, etc. 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 16. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Yes or No— If yes, specify Yes, GIVE WAR OR DATES 18. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Yes or No— If yes yes or No— If yes yes or No— If yes yes or No— If yes yes or No— If yes yes yes yes yes yes yes yes yes yes								Whits, atc.			
ED B	white								White			
1	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)											
COMPL	8th Grade	dialotte (a ad)		HC	omemak	ter		to Mortiemio via		1 Home		
_	Rudolph Sm								ME (First, Middle, Melder unter Hall			
BE	19s. INFORMANT'S NAME (11	b. MAILINO	ADDRESS	(Street a		Route Number, City or Tov		Code)	
TO B	Mrs. Doroth	v J. N	orth						ndallstown		211	33
	20s. METHOD OF DISPOSIT	TION		20b. PLACE	AND DATEO	F DISPOSI				OCATION — C		
	1 Densilon 5 Othe		over from State	Carro	ematory or other	rer place) emat:	ion.	Inc.	10-17 на	ampste	ead.	MD
	21. SIONATURE OF FUNER	AL SERVICE LIC	ENSEE			22. N	AME AN	D ADDRESS OF FA	CILITY			
	Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD											
	23. PART . Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between interval Between											
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Onset and Death Ryru											
DICAL CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):											
EDICAL C	PART II. Other significent conditions contributing to death but not resulting					n ths un	ths underlying causa given in Part I. 24a. WAS AN AUT PERFORME 1 TYES 2 2			RMED?	AVAILABLE PRIOR TO	
Σ									YES 2 NO			
SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN .											
SICIAN:	26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpetiant 3 DO 4 Nursing Home 5 Residence 8 Other (Specify)											
РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending 28s. DATE OF INJURY (Month, Day, Year)				28b. TIMI	b. TIME OF 28c. INJURY AT 28d. E				d. DESCRIBE HOW INJURY OCCURED		
TED BY	2 Accident Investigation 3 Suicide s Could not be determined 26s. PLACE OF INJURY — At home, building, etc. (Specify)				ome, ferm, s	M 1 YES 2 NO reet, factory, office 26f. LOCATION (Street and Number or Rural Route Number City or Town, State)			ute Number,			
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
TO BE COM	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, D3 7 8 8 2 10 16 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Profit) Resistant								11/2-			
Ē	30. NAME AND ADDRESS (۷.	Moss	11		Print)	'n-e J	s Can	to Dis	· R	2114	len Love,
	31 OCT 1 1 8 19	95 Ju	32. REGISTR	AR'S SIGNATURE								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



Pages 1, 2, 3 should

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funeral director, page 5 should

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HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 02:30 OCTOBER MARVIN Т. BURKINDINE SR. 15 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 6. AGE (In yrs. last birthday) HOURS 1 X M 2 | F 215-24-2069 63 28 193 MARYLAND Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR 6903 GLEN RIDGE CIRCLE B-1GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ANNE ARUNDEL MARYL AND GLEN BURNIE 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 16g, CITIZEN OF WHAT COUNTRY? 6903 GLENRIDGE APT B 21060 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BY 1 TYES 2 TO NO Specify 3 Widowed 4 Divorced KOREAN CONFLICT WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 12 FIRE FIGHTER BALTO. CITY FIRE DEPT. once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) Ħ FREDRICK H. BURKINDINE ROBERTA HERMAN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 903 SUNNYBROOK CT GLEN BURNIE MD 21060 LAWRANCE D. BURKINDINE must be 20s. METNOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State GLEN HAVEN MEMORIAL PARK 10/19 GLEN BURNIE, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY SW GLEN BURNIE MD 21061 medical 23. PART I. Enter the diseases of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition Dez resulting in death) event, AS A CONSEQUENCE OF traumatic CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other OUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 10 injury. PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? AVAILABLE PRIOR TO YES 2 NO any COMPLETION OF CAUSE OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 \(\text{Nursing Nome } 5 \) Residence 8 \(\text{ HOSPITAL 1 X YES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 6 28a, OATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c, INJURY AT WORK? 27. MANNER OF DEATN Is marked, 1 Natural 5 Pending investigation 0215" 95 1 YES DIRECTOR: After the hours after death villem 28 is mari BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify). Suicide 6 Could not be COMPLETED 4 Nomicide 03 29a, CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and pla TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: I and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCTOBER 15 1995 O.C.M.E. 2 30. NAME AND ETED CAUSE OF GEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 34. RECISTRAR'S IGNATURE 31. OATE FILEO (Mo

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writin 24 hours after death. Page 6 may be retained by the hosp	THE FUNEFAL DIRECTOR: After this certificate has been signed by the attention physician and completely find in by the funeral director, page 5 should be detached to the complete of the funeral director, page 5 should be detached to the complete of the complete of the funeral director.	be find within 12 hours after death with the state begin of health and wenter hybring prior to burds, cremators, or removes. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Last)	Frances Lu	cy Bederk	га		2. DATE OF DEAT MONTH	N DAY	YEAR 995	21:08	м
	4. SOCIAL SECURITY NUMBER 105-14-2796	5. SEX 1 M 2 X F 7 5 7 YRS. 6. AGE (In yrs. last birthday) 1 F UNDER 1 YEAR 1 F UNDER 24 HI MONTHS DAYS HOUPES ME				7. DATE OF BIRTH (Month, Day, You AUG. 2,			CE (State or Foreig	'n
TOR HO	Johns Hopkins Ba				timore C		9c. COUN	N/A	1	
DIRECTOR	100. STATE 100. COUNT Maryland				ion Dun	10d	I. INSIDE CITY LIMITS? YES 2XXNO			
FUNERAL	100. STREET AND NUMBER 3482 McShane Way			101	ZIP CODE 212	22		ted S		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3(X) Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 100	If yes, specify Cuban, Maxican, Puerto Rican, etc.)					American Indian, nita, etc. White	1
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) & Years	Cation ocompleted) College (1-4 or 5+)	60. DECEDENT'S USU (Give kind of work life. Do NOT use ret House	done during mo lired.)	ring most of working					
COM	17. FATHER'S NAME (First, Middle, Last)		110 003 €	2000	16. MOTNER'S NA	ME (First, Middle, Me	alden Surname)			
TO BE	190. INFORMANT'S NAME (Type/Print) Mr. Daniel Beder	177 Williams of Florida Florid					r Town, State, Zip	Code)	22	
	20e, METHDO OF DISPOSITION	20b. Pi	LACE AND DATE OF DI	ISPOSITION (Na	me of	DATE 20	c. LOCATION —	City or Town,	sum aryland	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AT Dud 792	a-Ruck F 2 Wise A	uneral H	lome of Idalk, 1	Dunda ID 21	lk, Inc 222	
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C	espirate consequence of: consequence of: doing	70	· lune	nary d		eat,	Approximate Interval Betwoen and D M minus	тееп
PHYSICIAN: MEDICAL CER	PERFORMED? 1 YES 2 NO OF						RE AUTOPSY FINDI ILABLE PRIOR TO MPLETION OF CAU DEATH? YES 2 NO			
I AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	26	DEATH YES		UNCERTAI	N 🗆				_
YSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	lent 3 DOA 4 (8 Other (Specify				
ВУ РН	Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		URY AT PRK? YES 2 NO	28d. DEŞCRIBE N	OW INJURY OCC	CURED		
	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY — building, etc. (Specify	- At home, farm, stree	it, factory, offic	•	281, LOCATION (S City or Town,	treet and Number State)	or Rural Route	Number,	
COMPLETED	ana)	SICIAN: To the best of my knowled							d manner aa state	d.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	-0 1	20.0		29c. LICENSE NU	WBER	29d. DAT	E SIGNED (Mo	onth, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WI	0000	N (ITEM 27) (Type, Pril	71)	4541473	רלושרט	0	ctobe	-15,1	795
	Janu Black	mo Ton	ver Bo	ل 🗴	ohms	Hopki.	-> H	rpit	~	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	AL.			,				

3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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995 '00 A M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR / IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 28-18-5080 1 - M 2 X F Va Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NA Ma saltimore TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 2/2/5 148 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO Specify: В 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elevator NA grade Derator utzler once. 17. FATHER'S NAME (First, Middle, Last) Johnson Ħ BE notified INFORMANT'S NAME (Type/Print) 2 Mil 21215 after death. Page 6 may be pe e METHOD OF DISPOSITION
Burlel 2 Cremetion 3 Removal from State 2093 LOCATION 182TE must Buriel 2 Cremenon funeral director, examiner FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 2/215 the 23. PART I. Enter the diseases, or complications that c shock, or heart-failure. List only one ceuse medical Approximate Interval Between of dying, such as cardiac or respiratory arrest. filled in I Onset and Daath IMMEDIATE CAUSE (Finel the cremation disease or condition resulting in death) event, COM and con burial, traumatic CERTIFICATION Sequentially list conditions, 2 ending physician a if any, leading to immediate cause. Enter UNDERLYING C CAUSE (Disease or injury other TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any Health a 1 | YES 2 shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN certificate has be the State Dept. 23 26. PLACE OF DEATH (Check only one, Item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 10 26a. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED this c marked, 1 2 Natural 5 Pending investigation 1 YES 2 NO BY After the 28s. PLACE OF INJURY — 2 Accident 3 Suicide At home, ferm, atreet, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 COMPLETED 8 Could not be DIRECTOR I 200 4 Homicide Item 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and my knowledge. TO THE HOSPITAL (
TO THE FUNERAL D
BE filed within 72 h
IMPORTANT: If It (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data 296. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Disharoon 31. DATE FILED 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTA	L HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)		021111110	ALC OF BEATH	2. DATE	OF DEATH		3, TIME OF DEATH
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	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) II	UNDER 1 YEAR IF UNDER 24 HRS	7 DATE	OF BIRTH	175	BIRTHPLACE (State or Foreign
	421 28 2812	1 - M 2 X F 70		NTHS DAYS HOURS MIN.		h, Day, Year)		Country
_	9a. FACILITY NAME (If not institution, give a	treet and number)	9	. CITY, TOWN OR LOCATION OF	DEATH	1	9c. COUNTY	OF DEATH
CTOR	RESIDENCE OF DECEDENT	MARKLIR	دلد	PARKVILL			LYAL	limore
DIRE	100. STATE 100. COUNTY	Timore	10c. CITY, 1	ARKILLE				10d. INSIDE CITY LIMITS? 1 YES NO
FUNERAL	10a. STREET AND NUMBER 8420 HALL	JARK LIR	262	101. ZIP CODE	314		10g. CITIZEN	OF WHAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECENDENT OF HIS			or No.— 14.	. RACE — American Indian,
ВУ Е	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuban, Max 1 TYES 2 NO Spe		Rican, etc.)		Specifys
요	15. DECEDENT'S EDU	CATION	18e. OECEOENT'S US	UAL OCCUPATION	166	. KIND OF BU	SINESS/INDUS	TRY
ᇤ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	done during most of working etired.)				1.9
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COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First,			
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100	19a. INFORMANT'S NAME (Type/Print)	W Issaich	19b. MAILING AC	DRESS (Street and Number or Rui	al Route Num	ber, City or Tow	n, State, Zip Co	ide) SHIL
유	Mazzare A Car	250 58	RHAD	Hall Maak	C. 181	1 2/0	Pack.	: Us Maylon
	20a. METHOD OF DISPOSITION	20b	PLACE AND DATE OF	DISPOSITION (Name of	DAT	E 20c. LO	CATION — CIN	y or Town, Steta
	Buriel 2 Cremetion 3 Rem		ARKUUOD		10-	B P01	24-11	Maeylam
	21. SIGNATURE DE FUNERAL SERVICE LIS		Howar	22. NAME AND ADDRESS OF		HIT	ZIA LT	-),
	1000) /		EVAN CHA	15T G	EI. IT	more.	137
	100g 45	Non/		8800 HAKI	-0RD	KOB	0-1	ARKVILL
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications that caused List only one cause on e	I the death. Do not ach line.	enter the mode of dying, a	uch aa can	diac or reap	iratory arreat	t, Approximate Interval Between
	IMMEDIATE CAUSE (Final	1 10	- 111					Onset and Death
	disease or condition resulting in death)	. Here		ARDIAL	INF	ARCT	ION	
		DUE TO (OR AS A	CONSEQUENCE OF):					
N N	Sequentially list conditions,	b						
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					
일	CAUSE (Disease or injury	C. DHE TO (OR AS A	CONSEQUENCE OF):					
Ē	that initiated events reaulting in death) LAST	DUE TO (ON AS A	CONSCOUNCE OF J.					i
問目		d			-			
	PART II. Other aignificant condition	a contributing to death b	ut not resulting in	the underlying cause given	In Part I.	24a. WAS AN		24b. WERE AUTOPSY FINDINGS
MEDICA						PERFOI	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 123	110	OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO 型 UNCERTA	AIN 🗆			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH			L		
SC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp		THER:	n a 🗆 Oth	ne (Spacifu)		
🖺	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME (OF 28c. INJURY AT			NJURY OCCUP	RED
	Natural 5 Pending	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO				
ВУ	2 Accident Investigation 3 Suicida a Could not be	28s. PLACE OF INJURY	- At home, farm, stre	et, factory, offica				Rural Route Number,
밀	4 Homicide 8 Could not be	building, atc. (Spec	cify)			or Town, State,		
iu l	29a. CERTIFIER	IOIANI, To Mark I in the internal in the inter	4-d dW					
OMPL	(Check only			et the time, data and place, and in my opinion, death occured at				
8			sador mysanganon,			- enu piaca, at		
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	Park	lin	29c, LICENSE I		,	29d. DATE S	SIGNED (Month, Day, Year)
0	wee we	- work	- 100 /		966	<i>-</i>	10C	1.13 142
	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) / Time D	int)				

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OCT 1 81995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

S. PARRA

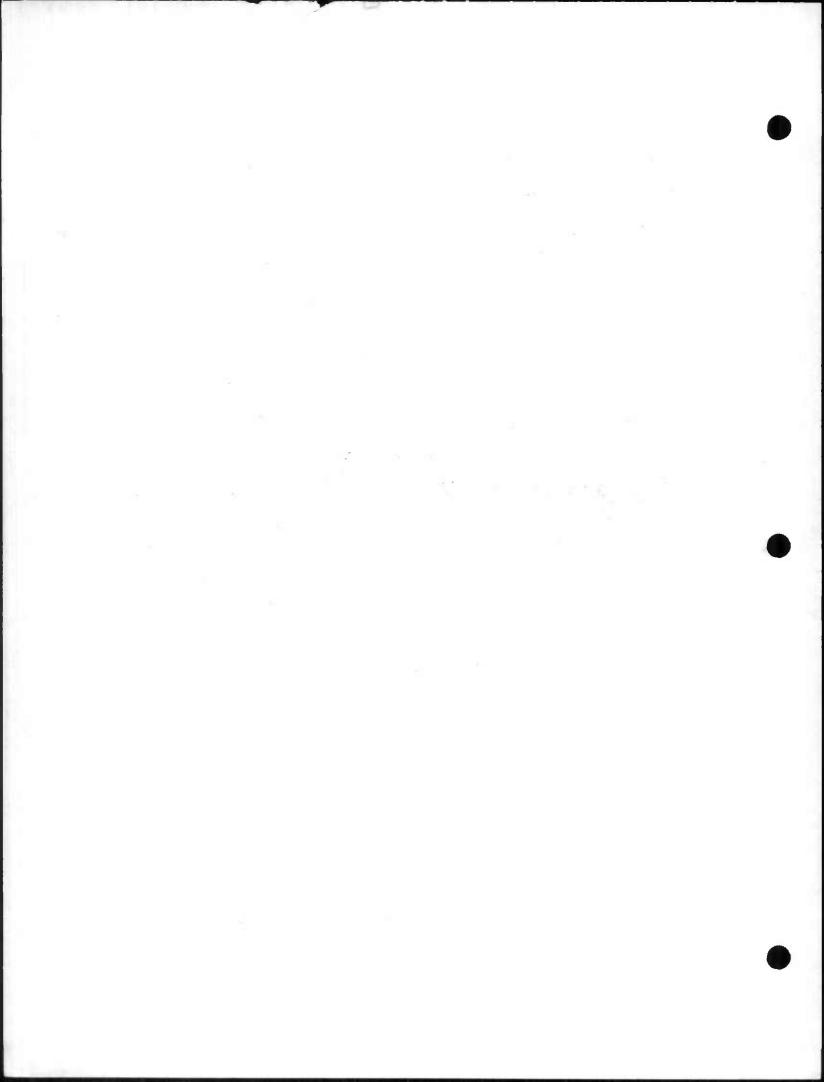
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or steen signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND I F DEATH	MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	AV	YEAR	3. TIME OF DEATH
	Lillian H.	HENOWETH				OCT 11	199		11200 4
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthdey)	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
	215-01-3518 98. FACILITY NAME (If not institution, give		YRS.			DCT 27.1	9121	Ma	- I CM IC
œ	2915 ANDOR	•		PARKY	OR LOCATION OF DE	ATH		TY OF DE	ATH NORE
6	RESIDENCE OF DECEDENT	X C1		1 HKNV	1666		UA	- mal 111	NURE
DIRECTOR	10a. STATE 10b. COUN			Y, TOWN OR LOC					10d. INSIDE CITY LIMITS?
		ALTIMORE	,	ARKV					1 YES 2 NO
RAI	2915 ANDOR	A CT			101, ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13 WAS D		IIC ORIGIN? (Specify Yes			- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes,	specify Cuban, Maxica ES 2 NO Specify	n, Puerto Rican, etc.)	01110	Black, Specify	White, atc.
BÁ	3 Widowed 4 Divorced			2	0,200,				HITE
빌	15. DECEDENT'S EC (Specify only highest grad		16a. DECEDENT'S (Give kind of	USUAL OCCUPA work done during se retired.)	TION most of working	16b. KINO OF BU	SINESS/INDU	USTRY	
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	OFFICE			Gener	raln	Not	DRS
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	~	011100		18. MOTHER'S NA	ME (First, Middle, Meiden	Sumamel		
	Herman L. H	teyn			Minni	e B. For	uble		
BE O	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	et and Number or Rural I	Route Number, City or Tow	m, State, Zip	Code)	
임	BILL RUTHER	FORD	2221	Micc	mico Ka	1 Baltim	ore,	Mq	. 21221
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ra		b. PLACE AND DATE	ther place.	(Neme of	10/-/	CATION — C		rn, State
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE	Visebur		AND ADDRESS OF FA	CHLITTY	HITE		DIVI
		0(1)	(_	EVA	NS CHAF	EL of Me	mori	es,	
	Travertil	Lace	11	86	OO HAR	FORD RA	Bal	to.	NG SISBA
	23. PART i. Effer the diseases, or ahock, or heart failure	r complications that cause a. List only one cause on a	d the death. Do	not enter the r	node of dying, auc	h aa cardlac or resp	iratory arre	est,	Approximata interval Between
- 1	IMMEDIATE CAUSE (Final disease or condition	acuto.	Much	, ac d	of the	Langt			Onset and Death
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE O	P:	THE OTHER	rac CI			
Z	Control and all the last and all the control a	ASCV	Du	si the	pera	le he	CV.	1	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	7 . 0	Hr 12.	ela	1 4 4 .		
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (O) AS	A CONSEQUENCE O	Die	118/12	run	an		
E	resulting in death) LAST	OSTED1.	0000	20 ~	sever	e wst	h.		
	DARY II OAL - I - III - I - I - III	Carrello	uni	au 4	La OF	tune	ac 9	efin	2
SE	PART II. Other significant condition	one contributing to death	De H	h the underly	ing cause giften in	PERFO	RIMEDT /		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	Saub	he seco	175 00	- 00	auce	O TO YES I	NO		OF DEATH?
Σ	DID TOBACCO USE CON			ES XI NO			1		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE (28. PLACE OF DEA			10			
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out	tpetient 3 DOA	OTHER:	ome 5 Residence	6 Other (Specify)			
ξ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		E OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCC	URED	
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 6 Could not b	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, farm, ecify)	atreet, factory, o	ffice	281. LOCATION (Street City or Town, State)		or Rural Re	oute Number,
COMPLETED									
릴	2001	YSICIAN: To the best of my know							
흥		NER: On the beele of axamination	on eng/or investigati	on, in my opinior					
出	296. SIGNATURE AND TALE OF CERTIF	LIIM,	110		29c. LICENSE NUI		29d. DATE	SIGNEO	(Month, Dey, Year) 2/199(
၉	30. NAME AND ADDRESS OF PERSON V	WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Turn	, Print)	I DO 51	.80	1 /	U/l.	4/1773
	DR. I. W. FROM		14 OLD		-1 R1	Balto N	14.	212	34
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE	TICH 10	19 110	CUATO. I	161	1 (14)	
	OCT 1 81995 S	falia d'audecrita	dall						



BA	ŏ
m	a law requires that the death certificate be executed within 24 hours after de
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DIVISION OF VILAL RECORDS, P.O. BOX 68/60	MIE
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The state of the s	TO THE MUSHIAL ON ALTERDING PHYDIAN: THE TAW FEQUITES THAT THE DEATH CENTIFICATE DE EXECUTED WITH TAY HOURS AFEC EATH. PAGE 6 May be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit nermit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
STATE AND DE	TO THE MOSPILA	TO THE FUNERAL	be filed within 72	IMPORTANT: If	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	M	3	. TIME OF DEATN
		Mineberg	CARA	IES		DOTOBER	16 1	995	12.55 A M
7	I A STATE OF THE S		E (In yrs. leet birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTI	, T	A BIRTHE	ACE (State or Foreign
	214-01-1298 1 Sa. FACILITY NAME (If not inetitution, give atree		77 YRS.			August 2			
R	Good Samaritan Hos				imore C:		9c. COUN	N/A	TN
CTC	RESIDENCE OF DECEDENT	prear		Dai	Tillor C C.	i cy		11/ //	
DIRECTOR	Manay Land	/ 4	10c. CITY	TOWN OR LOCAL		· 4			od. INSIDE CITY
L D	Maryland N	/A			zimore C	ıty			YES 2 NO
RA	2632 East Northern	Pkwy		10	21214			J.S.A	AT COUNTRY?
BY FUNERAL	11. MARITAL STATUS	2. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		NIC ORIGIN? (Specif			- American Indian,
YF	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 X YE		If yes, sp	ecify Cuben, Maxic 2 NO Speci	an, Puerto Rican, etc	-)	Black, V	Vhite, atc.
	** 2.44_31 = == - //ic	WW II	I sullis viscos aces						hite
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted)	(Give kind of w	ork done during me	ON st of working	16b. KIND O	BUSINESS/INDU	ISTRY	
PL	12	College (1-4 or 5+)	Lin	eman			Telecor	mmuni	cations
SON	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	AME (First, Middle, Me			
BE	Edwin Carnes					olland			
2	19a. INFORMANT'S NAME (Type/Print) Carol Lee Werner		19b. MAILING	ADDRESS (Street	nd Number or Rural	Floute Number, City o	Town, State, Zip (Code)	
	204, METHOD OF DISPOSITION					ltimore,			
	1 🖄 Buriel 2 🗆 Cremation 3 🗀 Remova 4 🗆 Donation 6 🗀 Other (Specify)		THE CONTRACT OF THE CONTRACT O			19,95 P	LOCATION C		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	new .		-	ID ADDRESS OF F		AI KVIII	5, mai	yrana
	repren f.	deffrey	L. Gair	Leona	rd J. Ru	ck, Inc.			land 21214
	23. PARTY. Enter the dispesses, or con	officetione that ceus	ed the desth. Do no	15305	de of dylog, eur	Road Ba.	timore.	.Mary	land 21214
	ehock, or heert fellure. Lia IMMEDIATE CAUSE (Fins)	t only one ceuse on	each line.		ar or aying, out	ar de derdiec of r	espiretory erre	wt,	Interval Between Onset end Deeth
	disease or condition resulting in death) a. BRAINSTEM HEMORRHAGE						9 DAYS		
	resulting in death) . a	DUE TO (OR AS	A CONSEQUENCE OF);	, -,				4443
N N	Sequentially list conditions,								
YAT.	If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
E	CAUSE (Disesse or Injury c	DUE TO (OR AS	A CONSEQUENCE OF	:					
CERTIFICATION	resulting in death) LAST								
	PART II. Other eignificent conditions of	ontributing to death	but not resulting is	the underlying	ceuee alven in	Part I 24a Will	S AN AUTOPSY	24b WI	ERE AUTOPSY FINDINGS
MEDICAL	POSTERIOR U	NALL MY	DCARDIAL	INFAI	RCTION	PE	RFORMED?	AM	AILABLE PRIOR TO DMPLETION OF CAUSE
AED	CHRONIC RI					_ '''	S 2 NO		DEATH?
ž	DID TOBACCO USE CONTRIB			NO E	UNCERTAI	N D		'	_ TEO I (g) NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	28. PLACE OF DEATH						
IXSI		Inpetient 2 - ER/Ou	tpetient 3 🗆 DOA		5 🗆 Residence	6 C Other (Specify)			
PH	1 Matural 6 Pending	(Month, Day, Year)	26b. TIME	RY WO	PK?	28d. DEŞCRIBE N	OW INJURY OCCU	JRED	
BY	2 Accident Investigation 3 Suicide & Could and be	28e. PLACE OF INJUR	IY — Al home, lerm, st		ES 2 NO	261. LOCATION (St	and and Montan	0 -10 -	
	4 Nomicide 8 Could not be	building, atc. (Sp	ecify)	ives, rectory, offic		City or Town, S		r Huriii Houli	Number,
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	N: To the best of my kno	wiedge, death occurred	of the lime date	and place, and due	to the enuerial and			
NO.	(Check only one) 2 MEDICAL EXAMINER: C								nd menner as stated.
ш	29b. SIGNATURE AND TITEE OF CERTIFIER	1			29c. LICENSE NUI				onth, Day, Year)
TO B	7. Chuain Balenz.				182	34			, 1995
۲	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF D	EATN (ITEM 27) (Type, I	Print)					
	JOSEPH BRATENS			IIAN H	ost., BA	LTIMORE	MD 21	239	
	111111 100-	32. REGISTRAR'S SIG							
	700	4 author	W-M						

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BALTIMORE, MARYLAND 21215-0020

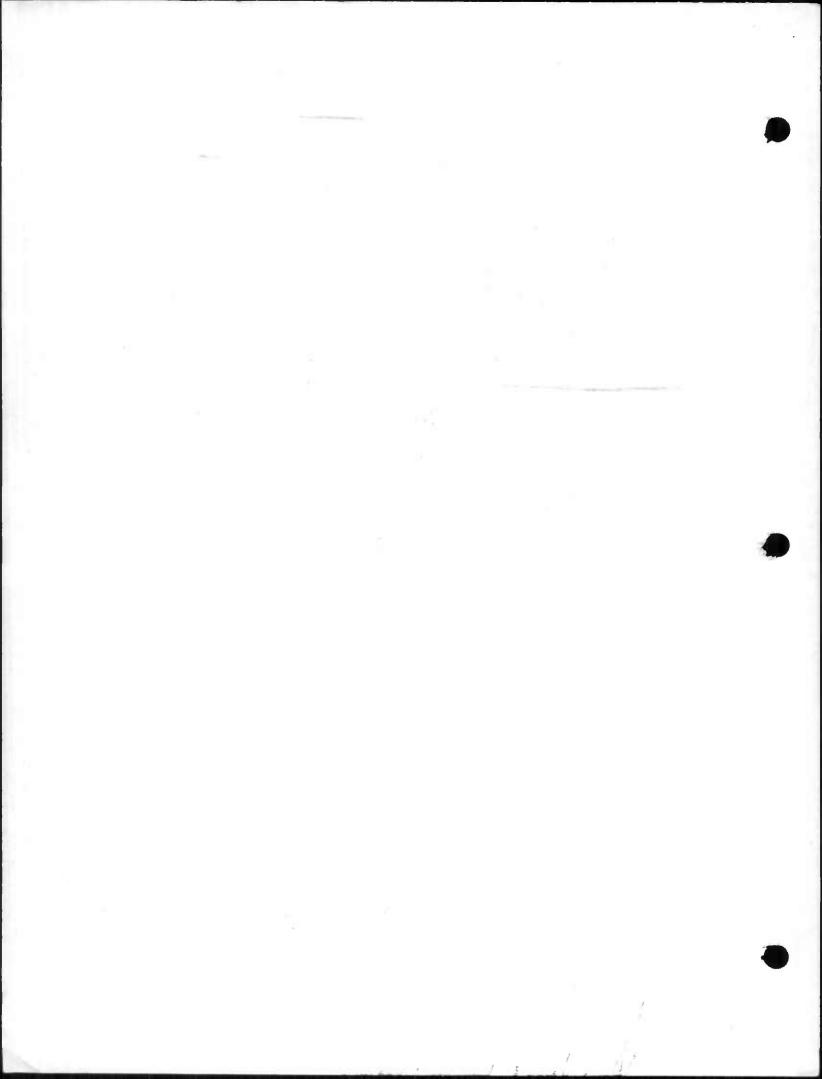
DIVISION OF VITAL RECORDS, P.O. BOX 6876

ITEMS: 23 PART I,27, 28a-f, PER MEO FILM G-728 10/20/95 t.t

Iteml,7,17,FiJm728,10/18/95,1t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1.	REGISTRAR	CE	RTIFICATE OF	DEATH	REG. NO		
	DECEDENT'S NAME (First, Middle, Last) ROLAND	STERLING	DORBI	TNOS	2. DATE OF DEATH DO		- 4
9	SOCIAL SECURITY NUMBER	Le ary La sar ii			OCTOBER	14 19	7
3	115-70-6487	5. SEX 6. AGE (In yrs. last	YRS. IF UNDER 1 YEAR DAYS	HOURS MIN.	7. DATE OF BIRTH 8	757 M	GUNTAPLACE (State or Foreign
1722	FACILITY NAME (If not institution, give s 300 MARTINGAI		96. CITY, TOWN BALTII	OR LOCATION OF DE		9c. COUNTY	
5 1	RESIDENCE OF DECEDENT						
H M	Mary And	JA	Balt	MOVE			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	300 Marti	nGALE AL	الا	DIZZ	29	10g, CITIZEN	OF WHAT COUNTRY?
	Marital Status Merried Merried Widowed 4 Divorced	12. WAS DECEDENT EYER IN U.S. ARI FORCES? YES 2 N IF YES, GIVE WAR OR DATES	O It yes, s	CENDENT OF NISPAN pecify Cuben, Mexica S 2 NO Specify		or No- 14.	RACE — American Indian, Black, White, etc.
C L	16. DECEDENT'S EDU (Specify only highest grade	ICATION 16a. DEG	CEDENT'S USUAL OCCUPAT we kind of work done during n	ION	166. KIND OF BU	SINESS/INDUST	haryland
COMPLET	Elementery/Secondary (0-12)		Do NOT use retired.)	DRICE	Balt	more C	ity Dentent
BE CON	PATHER'S NAME (First, Middle, Last)	BOAME DOBBINS	S	18. MOTHER'S NA	ME (First, Middle, Melden	Symomor	LD
10 B	SHIELGU DO	BBINS 3	D. MAILING ADDRESS (Street	end Number or Rural	PUE BO	n, State, Zip Cod	OVE Maryle
30	0e METNOD OF DISPOSITION Burlei 2 Cremation 3 Rem		AND DATE OF DISPOSITION (I	lame of	10/18/95	GATION — City	
	□ Donetion 5 □ Other (Specify)	Barr	ison forcet	Jet. Gem		xiax	s Mills, 1
21	1. SIGNATURE OF FUNERAL SERVICE LI	tengee	22. NAME /	AND ADDRESS OF FA	1453 407	SERTE	STOWN RU
2	" Duay D	uns	CHI	ATMBN-	HANIST.	1. Bali	timese, Mola
	esulting in death)	NARCOTIC AND ALCO DUE TO (OR AS A CONSECUE) b.					
TIFICATION	Sequentially list conditions, f any, laading to immadiata sause. Enter UNDERLYING	DUE TO (OR AS A CONSEC	DUENCE OF):				
ERTIF	CAUSE (Disease or injury hat initiated events eaulting in dasth) LAST	DUE TO (OR AS A CONSECU	DUENCE OF):				
	PART II. Other algnificant condition	ns contributing to death but not r	esuiting in the undariyi	ng cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FIND
8					PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
					l'	- 1	
¥	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	TH YES NO!	UNCERTAI	v 🗆	1	YES 2 NO
¥	DID TOBACCO USE CONT 5. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	E DF DEATN (Check only on		N D		
¥	5. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO	26. PLAC HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	OTHER: DOA 4 Nursing Ho	me 5 XReeldence	6 Other (Specify)		1 YES 2 □ NO
PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? TYPES 2 NO 7. MANNER OF DEATN 1 Netural 5 Pending	26. PLAC HOSPITAL:	DOA OTHER: DOA 4 Nursing Ho 28b. TIME OF INJURY 28c. IF)		NJURY OCCURE	1 YES 2 □ NO
ED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 7. MANNER OF DEATN 1 Natural 5 Pending	26. PLAC HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 28. DATE OF INJURY (Month, Day, 'ber)	E DF DEATN (Check only on OTHER: DOA 4 Nursing He 28b. TIME OF INJURY 2:15 A M 1	me 5 XResidence JURY AT ORK? YES 2XX NO	6 Other (Specify) 28d. DESCRIBE NOW UNKNOWN	and Number or B	1 YES 2 □ NO
ED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? TYPES 2 NO 7. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined	26. PLACE PLACE 26. PLACE 1 Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Yeer) 10-14-95 28e. PLACE OF INJURY — At ho	E DF DEATN (Check only on OTHER: DOA 4 Nursing Ho 28b. TIME OF INJURY 2:15 A M 1 me, ferm, street, fectory, off HOME	ne 5 [XReeldence IJURY AT YES 2X[X] NO	5 Other (Specify) 28d. DESCRIBE NOW UNKNOWN 28t. LOCATION (Street City or Town, Steet BALTIMORE C.)	and Number or B 300 MART TY, MD.	YES 2 NO
IPLETED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 7. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 4 Nomicide determined 9e. CERTIFIER (Check only 1 CERTIFVING PHYS	26. PLACE HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Yeer) 10-14-95 28e. PLACE OF INJURY — At hobuilding, atc. (Specify)	DOA OTHER: DOA 4 Nursing He 28b. TIME OF INJURY 2:15 A M 1 Time, ferm, street, fectory, off HOME	me 5 XResidence IJURY AT ORK? YES XXX NO	5 Other (Specify) 28d. DESCRIBE NOW UNKNOWN 28t. LOCATION (Street City or Town, Stele BALTIMORE C.) to the cause(e) end ma	and Number or B 2300 MART TY, MD.	D VIES 2 NO
IPLETED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 7. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 4 Nomicide determined 9e. CERTIFIER (Check only 1 CERTIFVING PHYS	26. PLACE HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Yeer) 10-14-95 28e. PLACE OF INJURY — At horbuilding, atc. (Specify) BICIAN: To the best of my knowledge, de	DOA OTHER: DOA 4 Nursing He 28b. TIME OF INJURY 2:15 A M 1 Time, ferm, street, fectory, off HOME	me 5 XResidence IJURY AT ORK? YES XXX NO	5 Other (Specify) 28d. DESCRIBE NOW UNKNOWN 28t. LOCATION (Street City or Town, Stete BALTIMORE C.) to the cause(e) end ma time, date and place, a	and Number or 8 300 MART TY, MD.	D VES 2 NO
O BE COMPLETED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? NOTE: 1	26. PLAC HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Yeer) 10-14-95 28e. PLACE OF INJURY — At hobuilding, atc. (Specify) SICIAN: To the best of my knowledge, de	E DF DEATN (Check only on OTHER: DOA 4 Nursing Ho 26b. TIME OF RAUJURY 2:15 A 1 1 me, ferm, street, fectory, off HOME ath occurred at the time, de	me 5 TResidence IJURY AT YES 2X[X] NO ice te and place, end due death occured at the	5 Other (Specify) 28d. DESCRIBE NOW UNKNOWN 28t. LOCATION (Street City or Town, Stete BALTIMORE C) to the cause(e) end ma time, date and place, a	and Number or R 1300 MART TY, MD. nner es stated. nd due to the ca	D VES 2 NO NO NO NO NO NO NO NO NO NO
TO BE COMPLETED BY PHYSICIAN: ME	5. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 7. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be datermined 9e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	26. PLAC HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Yeer) 10-14-95 28e. PLACE OF INJURY — At hobuilding, stc. (Specify) BICIAN: To the best of my knowledge, de ER-On the best of examination end/or in	E DF DEATN (Check only on OTHER: DOA 4 Nursing Ho 26b. TIME OF RAUJURY 2:15 A 1 1 me, ferm, street, fectory, off HOME ath occurred at the time, de	The state of the s	5 Other (Specify) 28d. DESCRIBE NOW UNKNOWN 281. LOCATION (Street City or Town, Stele BALTIMORE C) to the cause(e) end ma time, date and place, as	and Number or R 300 MART TY, MD. There existed. Ind due to the ca	urel Route Number, INGALE AVE. use(a) and menner ee state SNED (Month, Day, Year) BER 14 19



BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPIT	D THE FUNER	e filed within	MPORTANT

	FOR	STATE OF MARYLAND /	nepar:	TMENT OF F	IFAITH AN	ID MENTA	I HYGIFNI			, 501
	1 - STATE REGISTRAR			CATE OF			REG. NO.	-		
	1. DECEDENT'S NAME (First, Middle, Last) W//// A M	Elmer E	· b/	e		2. DATE MONT		Y /	995 3.	TIME OF DEATH 9:15 P M
	4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vis. lest birthday) IF INDER 1 YEAR IF INDER 24 HRS 7. DATE OF BIR					OF BIRTH			NCE (State or Foreign	
	216-34-7246	I X M 2 □ F 58	YRS.	MONTHS DAYS	HOURS M	HOURS MIN. (Morrith, Day, Year) MAY 19,1937 BALT			BALTC	O. MD
	9e. FACILITY NAME (If not institution, give street	et end number)		9b. CITY, TOWN	OR LOCATION O			9c. COUNTY OF DEATH		
TOR	ST. AGNES HOSPITAL			BALTIM	IORE					CITY
EC	10a. STATE 10b. COUNTY		10c. CITY	r, TOWN OR LOCA	TION				10	d. INSIDE CITY
	MARYLAND BALTIMORE BALTIMORE (ST.DENIS)								LIMITS?	
3AI	100. STREET AND NUMBER			10	f. ZIP CODE			, T	IZEN OF WHA	T COUNTRY?
Ä	1800 MAIN STREET				21227				S.A.	
BY	106. STREET AND NUMBER 1800 MAIN STREET 1. MARITAL STATUS 1. MARITAL STATUS 1. Marital STATUS 1. Marita									
ED	15. DECEDENT'S EDUCA			USUAL OCCUPATI		168	. KIND OF BUS	INESS/INC	DUSTRY	
PLET	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementarry/Secondary (0-12) 9TH GRADE 16a. DECEDENT'S USUAL OCCUPATION (Ghe kind of work done during most of working life. Do NOT use retired.) ASSEMBLY WORKER GENERAL MOTORS									
COMPL	17. FATHER'S NAME (First, Middle, Last)	1222					Middle, Meiden		OILD	
	GEORGE EDWARD EBLE				MADEI	INE ZI	NKAND			
BE	19e. INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (Street	end Number or F	Rural Route Num	ber, City or Town	n, State, Zip	o Code)	
5	MRS. WILMA L. EBLE	1	800 1	MAIN STR	EET -	BALTIM	ORE. M	D 21	227 (5	T. DENTS)
	MRS. WILMA L. EBLE 1800 MAIN STREET - BALTIMORE, MD 21227 (ST.DENI 20a. METHOD OF DISPOSITION 1 St Burlel 2 Crametton 3 Gramoval from State 4 Donation 8 Other (Specify) ST.LAWRENCE CHURCH CEMETERY 100 MAIN STREET - BALTIMORE, MD 21227 (ST.DENI 20b. PLACE AND DATE OF DISPOSITION (Name of Completery, crematory or other place) ST.LAWRENCE CHURCH CEMETERY 100 MAIN STREET - BALTIMORE, MD 21227 (ST.DENI 20c. LOCATION - City or Town, State 107 ST.LAWRENCE CHURCH CEMETERY 20c. LOCATION - City or Town, State 107 ST.LAWRENCE CHURCH CEMETERY									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC.						21220			
	IMMEDIATE CAUSE (Final									
	disesse or condition resulting in death) a.	DUE TO (OR AS A CONSE								27 h
		OUE TO (OR AS A CONSE	OUENCE OI	F):	Innh	plic	Pivo	10	1:200	10yrs
ERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS A CONSE			1000			64	, , and	7 9/15
3	CAUSE (Disease or Injury									
쁜	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF	F):						
E	d.									
0	PART II. Other significent conditions	contributing to death but not	resulting	In the underlyir	ng ceuse give	n in Part I.	24a, WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
DICA	PERFORMED? MAILABLE PRIOR						MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
							□ YES 2 🖺 NO			
PHYSICIAN:		26. PLAI HOSPITAL: 1 © Inpetient 2 = ER/Outpetient 3		OTHER: 4 Nursing Ho		ance BIT Cub	er (Snecilly)			
	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. IN	JURY AT ORK?	28d. DE	SCRIBE HOW I	NJURY OC	CURED	
BY	2 Accident Investigation	00. DI 405 05 WHITE			YES 2 N	-	DATION (C)			- M
0	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, ferm, i	street, rectory, offi	ce		CATION (Street or Town, State)		r or Hurel Flou	e numoer,

29c. LICENSE NUMBER PD 7532

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

Oct. 14, 199)

BE COMPLETED

9

29e. CERTIFIER (Check only one)

296. SIGNATURE AND TITLE OF CERTIFIER

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

WILL, Defaltone

July 32, right pars and ref

fe

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

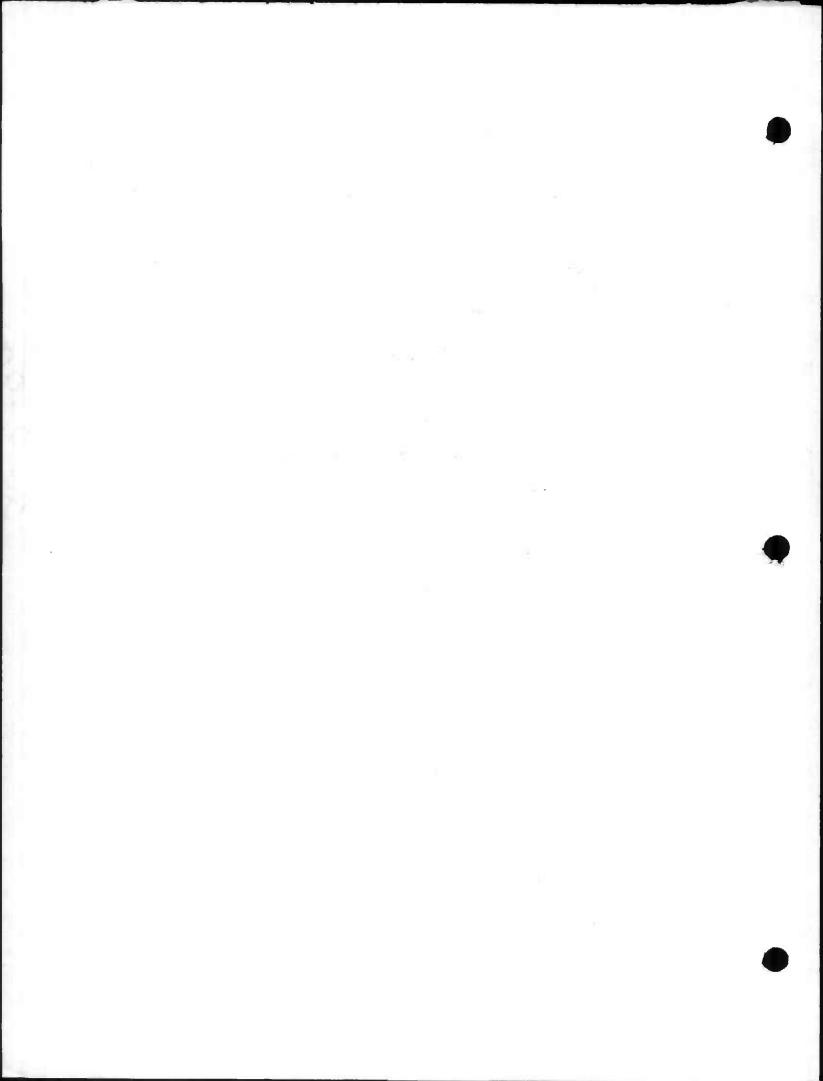
	REGISTRAR CERTIFICATE OF DEATH REG. NO.
	t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
	Manie Oreene October 15 1995 1923 m
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign
	015-18-0877 10 M 2 OF 19 YRS. MONTHS DAYS HOURS MH. Dec 10, 1915 Rentucky
	98. FACILITY NAME (If not institution, give street and nulinber) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
6	Northwest Stospital NIA Dalto
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION, 100. INSIDE CITY
Ĕ	Ma NA
	100. STREET AND NUMBER 101. ZIP CODE 100. CITIZEN OF WHAT COUNTRY?
H	1007 Cooks Lane 21229 U.S.A
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AFMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No. 14. RACE - American Indian
	1 Never Merried 2 Married FORCES? t YES 2 NO II yes, specify Cuben, Maxican, Puerto Rican, etc.) Black, White, etc.
В	Spaciny: Black
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 169. DECEDENT'S USUAL OCCUPATION (Sive kind of work done during most of working
	life Do NOT use patired.)
₹	10 H TIMES CHINASTES
	17. FATHER'S NAME (First, Middle, List)
H	90/INFORMANT'S PANS (Type/Print). C 19b. MAILING ADDRESS (Street and Number or Bural Route Number City or Town State Zin Code)
2	KALL IV JA F (MARCHET)
	206 METHOD OF DISPOSITION Burlet 2 Cremetton 3 Removal from State 206 PACE AND DATE OF DISPOSITION (Negrec) DATE 20c, LOCATION - City or Town, State 10/19/gg UDD aun nd
	1 Bonature of Funeral Service Licenses / 22, NAME AND ADDRESS OF FACILITY
į	Chame, H. Dhimoson To Harch fitt- West
	23. PART Enter the diseases, or complications that cause the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	interval Between immediate CAUSE (Fins) Interval Between Onset and Daeth
	disease by condition
	DUE TO (OR AS A CONSEQUENCE OF):
z	- Congestive Logo Phanlyre 2day
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO/(OR AS A CONSEQUENCE OF):
CA	CAUSE (Disease or Injury C. A S (V)
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST
H	d.
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PINDINGS
EDICAL	Semile Dementig - Ca - O Colon PERFORMED? AMAILABLE PRIOR TO COMPLETION DE CAUSE ON DESTREY
	OF DEATH?
. M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)
Sic	EXAMINER? 1 YES 2 THO TO THER: 1 Nursing Home 5 Residence 8 Other (Specify)
Ŧ	27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED
ВУР	t Meturel 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO
0	3 Suicide 28c. PLACE OF INJURY — At home, farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number.
E	4 Homicide determined building, stc. (Specify)
COMPLETE	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner se stated.
8	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
- 14	29b. SIGNATURE AND TITUE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, War)
BE	13 Mahr Mil att Mhyrician D-14610 > 10/17/45
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
	BIENVENIDO R. MATOS M.D. 21 Cran brook Rd: Cockeywill Md. 21030
	31. DATE FILED (Month, Day, Your) 22. RIGISTRI VS SENATURE
- 0	CESIO 1170

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)				T	2. DATE OF DEATH		3. TIME OF DEATH		
	EUGENE WILLARD	GLASS				OCT 9	1995	R' 1 15 0		
- 1			yrs. lest birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS,	7. DATE OF BIRTH	RTHPLACE (State or Foreign			
ŀ	423 12 010	MM2 = 78		ONTHS DAYS	HOURS MIN.	FEB 11,1917 VICGINIA				
-	9e. FACILITY NAME (If not institution, give street	end number)	9		R LOCATION OF DEA	TH	9c. COUNTY C	OF DEATH		
DIRECTOR	ST. JOSEPH MED	rica-Cente	Y	Tou	SON		DAL	-TIMORE		
Ä	10e. STATE 10b. COUNTY			TOWN OR LOCAT				10d. INSIDE CITY LIMITS?		
ā	MD BAL	STIMOTE	1-	ARKVI	lle			1 TYES 2 THO		
A	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN (OF WHAT COUNTRY?		
E 00.0 11 D1						USA				
3		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No — 14. F	ACE American Indian,		
	1 Never Married 2 Merried	FORCES? 1 YES			2 WNO Specify:	, Puerto Ricen, atc.)		Black, White, etc.		
BY	3 Widowed 4 Divorced	WWI		1	a light to opening.			VHITE		
ED	15. DECEDENT'S EDUCATE (Specify only highest grade con	ION	16a. DECEDENT'S US			16b. KIND OF BUS				
ET		College (1-4 or 5+)	life. Do NOT use i	rk done during mo. retired.)	st of worlding					
릴	6	-	CARPEN	UTER		Cons	TRUCTIO	NC		
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	E (First, Middle, Meiden	Surneme)			
0	Julius Glas	55			Zeli	a STON	F			
BE	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING A	DDRESS (Street e		oute Number, City or Tow)		
2	Tennie M. G	31055	8012	11 0	ford Ro	Balta 1		21234		
	20e. METHOD OF DISPOSITION	200	PLACE AND DATE OF				CATION — City of			
	1 Donation 5 Other (Specify)	I from State ceme	etery, cremetory or other	r plece	man have	18 Av. E.	LTD. M			
	21, SIGNATURE OF FUNERAL SERVICE LICENS		recrino	22. NAME AN	ID ADDRESS OF FAC		10:11	d .		
1	(Do 11 (())			& Memorie	\$			
	Taber US	Toves	a	8800	HARFO	RD Rd. Bo	elto. Mk	4.21234		
	23. PART I. Enter the diseases, or com shock, or heart failure. Lia	nplications that caused	the death. Do not	t enter tha mo	de of dying, such	as cardiac or respi	Irstory arrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final							Onset and Death		
	disease or condition	acute K	200irato	74 /	- Vine			12 Hour		
	disease or condition									
z	End steer COPD									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A) A	CONSEQUENCE OF):							
2	CAUSE (Disease or Injury									
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
E	resulting in death) LAST									
	PART II Other elgolfficent conditions	contribution to death to	at not resulting t	the rest 1.1	n anno anti-	Seed I are seen		24b. WERE AUTOPSY FINDINGS		
AL	PART II. Other significant conditions of	contributing to death bu	it not reaulting in				PERFORMED? AMAILABLE			
ă						1 YES 2	DING	OF DEATH?		
MEDIC								1 YES 2 NO		
ä	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	F DEATH YES	NO [] UNCERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATH							
Si		☐ Inpatient 2 ☐ ER/Outpu		OTHER:	e 5 Residence (B C Other (Specify)		10.0		
ξ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b, TIME		URY AT	26d. DESCRIBE HOW	NJURY OCCURE	D		
ВУ	1 Natural 5 Pending 2 Accident Investigation	,,	7.	M 1 🗆						
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Speci	- At home, farm, str	eet, factory, offic	•	281. LOCATION (Street City or Town, State)	end Number or Ri	ural Route Number,		
E I	4 Homicide datermined	annumy, ates (c)cocs				City of lown, State,	,			
"	290. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	adne death occurred	of the time date	and place, and due i	to the cause(s) and man	nner se stated			
COMPLET	nnel							use(e) and menner se stated.		
8				9				socioj ona memor os statos.		
BE	29b, SIGNATURE AND TITLE OF CERTIFIER	10 2			29c. LICENSE NUM	BER	29d. DATE SIG	NED (Morth, Day, Year)		
2	6	7 6	10		12397	247		10/12/95		
	30. NAME AND ADDRESS OF PERSON WHO	(man			0 11	11				
	UK. Michael Ko	9005	HARF	ord Ki	1. Balta	s.Mld. 2	21234			
	OCT 8 1995	22. REGISTRARIO SIGNA	ATURE							
	- 1000 June		7							



Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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BOX 68760 requires that the death certificate be P.0. RECORDS, DIVISION OF VITAL

OR ATTENDING PHYSICIAN: The law

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY VEAR ribson liam Octo ber 12:30 A.M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Your) March 31, 1921 Ken Maryland 220-24-8520 1 2 M 2 - F 69 Se. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH N/A Baltimore DIRECTOR Bon Secours Hospital RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10e STATE 10h COUNTY 10d. INSIDE CITY N/A Baltimore Maryland 1X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 2708 W. Lanvale Street 21216 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) Specify: Black 1 YES 2X NO Specify: BY 3 Widowed 4 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Щ Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction COMPL 6th once. 18. MOTHER'S NAME (First, Middle, Malden Sumame) 17. FATHER'S NAME (First, Middle, Last) Mary Rogers Charles H. Gibson notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 2708 W. Lanvale Street, Balto., MD. 21216 Elnora Gibson 9 20s. METHOD OF DISPOSITION

(★) Burial 2 □ Cremation 3 □ Removal from State 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Donation 5 Other (Specify) 10/17 Zion Cemetery Baltimore, Maryland FUNERAL SERVICE LICENSE medical examiner 22. NAME AND ADDRESS OF FACILITY
I.EROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 removal. complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on such line. hock, or heart to Approximate interval Batween ŏ Onset and Death IMMEDIATE CADSE (Final the disesse or condition and completely fi burial, cremation DUE TO TOR AS A CONSEQUENCE OF): resulting in desth) traumatic event, Dernhitno Jacan/ CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a ntal Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING malltms Aabets CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST 6 the attent Injury. PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE by th Dabetes sellow no state shows any signed | 1 YES 2 NO OF DEATH? Dely wonto rch 1 YES 2 NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 'UNCERTAIN | has be Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem this certificate h HOSPITAL: OTHER:
4 | Nursing Home | 5 | Residence | 8 | Other (Specify) 1 YES 2 1 NO 1 Inpetient 2 ER/Outpetient 3 DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 28d DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY After 1 death Investigation 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 89 hours after d 9 4 Homicide determined 58 Ш Item 29a. CERTIFIER
(Check only
one)

2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. COMPL TO THE HOSPITAL TO THE FUNERAL IDE filed within 72 h 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 295. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 004832 October 13, (991 tolends to Joh seringo 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROLINDS M 1. SABUNDAYO. 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) OCT 1 8 1995 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene orior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

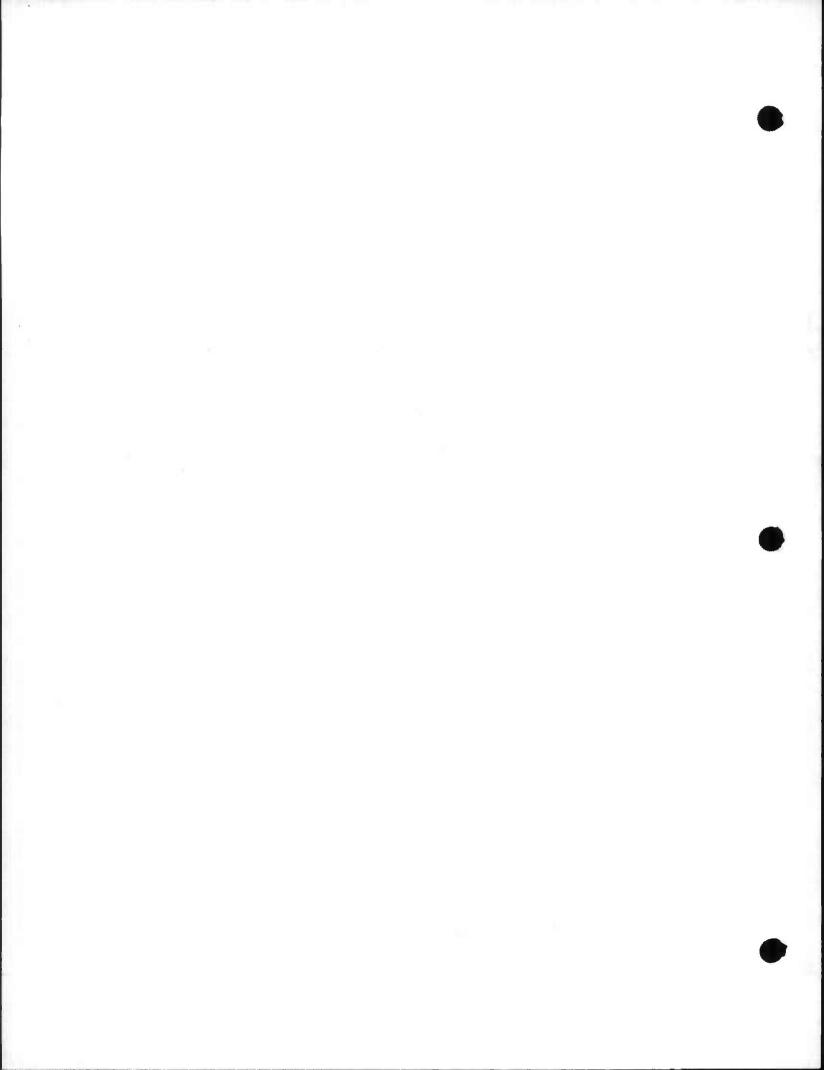
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH William Raymond Green Oct 17,1995 11:32 P 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 217-14-7944 71 XX M 2 1 Feb 26, Virginia 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 11608 Fort Washington Road DIRECTOR Fort Washington Prince George's RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Fort Washington 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 11608 Fort Washington Road 20744 United States 12. WAS DECEDENT_EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Wildowed 4 Divorced 2-22-43- 12-22-45 White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) Operating Engineer Heavy Equipment 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnen William Inman Green Wilmerton Marquerite Reese BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 11608 Fort Washington Road, Fort Washington, 20744 Regina B. Green 20e, METHOD OF DISPOSITION
XX Burlel 2 Cremation 3 Re
4 Donation 5 Communication 20b. PLACE AND DATE OF DISPOSITION (Name of Oct 20, 1995 20c. LOCATION — City or Town, State Maryland Veterans Cemetery □ Donation 5 □ Other (Specify) Cheltenham, Maryland 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Old Alexandria Ferry Road, Clinton, MD 20735 23. PART I. Enter the shock. eeesea, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiec or reapiratory arrest, heert failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Ogast and Death** disease or condition resulting in death) months e No carchoma THE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 - YES 2 100 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:
4 | Nursing Home | Standarder | 8 | Other (Specify) 1 | YES 2 |) 1 | Inpatient 2 | ER/Oulpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be delarmined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to like cause(e) and manner se stated. of examination and/or investigation, in my opinion, death occured at the lime, date and piece, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ye 9

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2. REVISTRA

26

DHMH-18 Rev 1/89



YEAR

1995

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

N/A

USA

3. TIME OF DEATN

1450

10d. INSIDE CITY

TXXYES 2 NO

White

21231

Approximate Interval Between Onaet and Death

1 da

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 | YES 2 | NO

29d. DATE SIGNED (Month, Day, Year) 10-16.95

dou

8. BIRTNPLACE (State or Foreign Country)

W. Virginia

14. RACE — American Indian, Black, White, etc.

REG. NO

2. DATE OF DEATH MONTH

Oct

FOR

1

STATE REGISTRAR

1, DECEDENT'S NAME (First, Middle, Last)

Arthur Matthew Gross

5. SEX

4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 232-44-0091 MIN. 1 XM 2 - F 66 8/29/1929 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Deaton Medical Center Baltimore RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION N/A Maryland Baltimore permit 10e. STREET AND NUMBER 101. ZIP CODE FUNERAL been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and Mental Hygiene prior to burial, cremation, or removal. 611 S. Charles Street 21230 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Unknown COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondery (0-12) College (1-4 or 5 +) 7th Glass Worker Factory 16. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) Arthur Dolly Gross Taylor H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Arthur Gross 2538 Fait Ave. Baltimore, Maryland 21224 20s. METNOD OF DISPOSITION

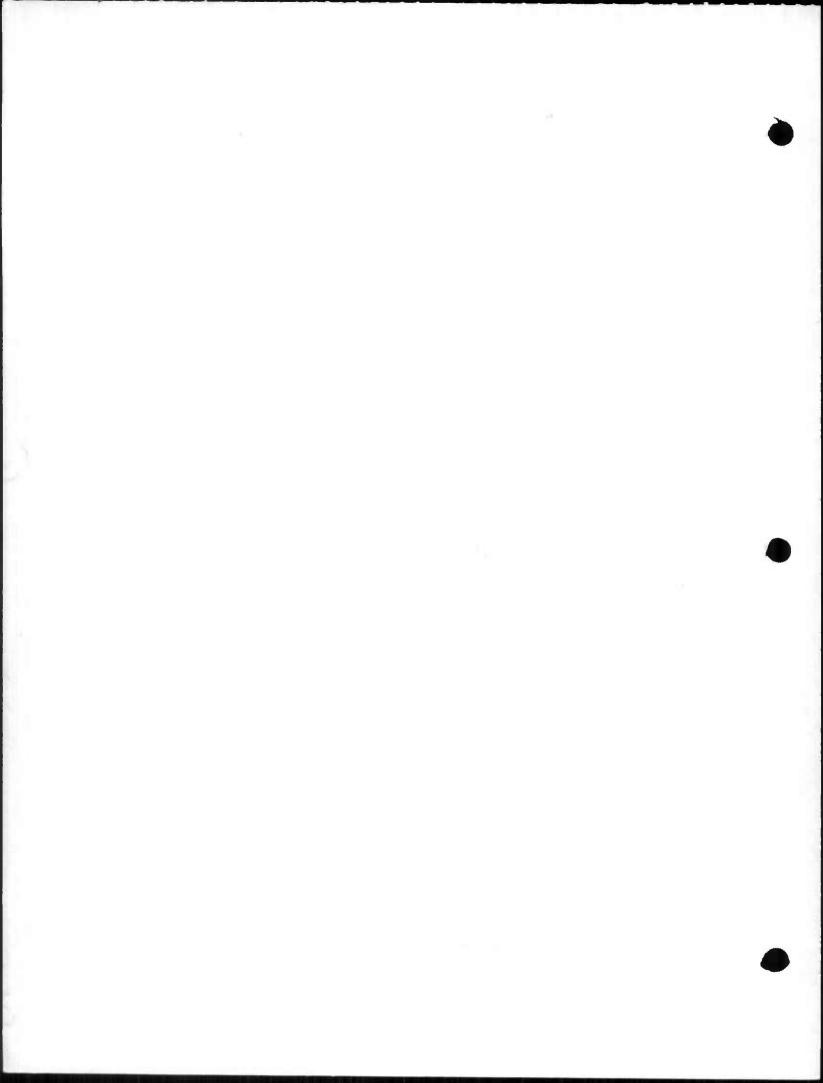
1 G/Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Beahm's Chapel Cemetery 10/18 Luray, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester Street Balto. Md. 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or hear fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disesse or condition birat ion reaulting in death) requires that the death certificate be executed with CERTIFICATION Sequentially list conditions. TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) After this certificate hadeath with the State D marked, or item Item OTHER:
4 Nursing Nome 5 Residence 6 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATN 28c. INJURY AT WORK? 26e. DATE OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF INJURY this c. 1 Natural 1 YES 2 NO After 1 death BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: Aft hours after des item 28 is n 3 Suicide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 1 🗹 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee stated. TO THE FUNERAL OF THE FUNERAL DE FILED WITHIN 72 NO IMPORTANT; If IN 2 MEDICAL EXAMINER: On the beels of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER CPuchtani) D34974 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)
5865 Robert olives place # 121. Columbia, MD 21045 31. DATE FILED (Month, Day, Year)
OCT 1 8 1995 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

6. AGE (In yrs. lest birthday)

DHMH-16 Rev 1/89



DHMH-18 Rev 1/89

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1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 1640 (No middle initial) Gadd 13 Franklin October 0. BIRTHPLACE /State 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. DAYE HOURS SHIPI. February 26 1923 USA 215-12-040. 1 M 2 - F YRS. Pages 1, 2, 3 should 90. FACILITY NAME (If not institution, MERCY ME 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MEDICAZ Baltmars BALtimores. DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 1 X YES 2 - NO Maryland none Balto.City, Md. permit. FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 600 Light St. Apt. 911 use as the burial-transit 21230 United States be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 25 NO Specify: 1 Never Married 2 Merried
3 Widowed 4 Divorced Spectly White BY Army, W.W. 2 COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) 104 Elementary/Secondary (0-12) College (1-4 or 5 +) detached 12th.Grade Laborer Relation C.S.X. none once. 17 FATHER'S NAME (First Middle Lest) 18. MOTHER'S NAME /First Middle Maiden Surname) Franklin R. Gadd Ursula Johnson 2 To notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 600 Light St, Apt. 911, Balto. Md. 21230 Mrs.Rita H.Gadd Pe 20e. METHOD OF DISPOSITION
1 XBuriel 2 Cremation 3 Removal from State
4 Donation 8 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must funeral director, Cedar Hill Cemetery, 10/17/95 A.A.Co.Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 examiner McCully Funeral Home, 130 E. FortAre. and completely filled in by the burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heert fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the months disease or condition opathic lumans resulting in death) event, DUE TO JOR AS A CONSEQUENCE OF traumatic MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 0 if any, leading to immediate cause. Enter UNDERLYING attending physician CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Wental A Injury, 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? PART II. Other algnificant conditions contributing to death/but not resulting in the underlying cause given in Part I. Alo throm bour & menia signed by the AspegillomA any 1 | YES 2 | NO Health OF DEATH? Shows VA9 culor distase 1 YES 2 NO has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: r this certificate h OTHER:
4 | Nursing Home 5 | Residence 1 YES 2 XNO Inpatient 2 - ER/Outpatient 3 - DOA 0 27. MANNER OF DEATH 28c, INJURY AT WORK? 28a. DATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR; After the hours after death w 87 Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 40 6 Could not be COMPLETED 28 4 Homicide datermined Hem 29e. CERTIFIER 1 CHAPTER AND 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner ea stated. TO THE HOSPITAL O
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If it THE HOSPITAL (THE FUNERAL D filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIED US 29c, LICENSE NUMBER BE 30. NAME AND AGGRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 9

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	A ATTENDING PHYSICIAN. The law requires that the death certificate he executed with

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the mediçal examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	- REGISTRAR		CE	ERTIFICA	ATE OF	DEATH		REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, Last)				1.0-			OF DEATH			3. TIME OF DEAT	Н
	DOROTH	14	C	H	ARR	ISON	MONTH	_ 1 /	-9	YEAR	235	DW
	4. SOCIAL SECURITY NUMBER 5	. SEX 6.	AGE (In yrs. les	t birthday) IF t	JNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTHE	PLACE (State or Fo	nian
	213-44-8398	☐ M 2 💢 F	90	YRS. MON	THS DAYS	HOURS MIN.		Day, Year)	005	Country)	vangii.
	9a. FACILITY NAME (If not institution, give stree	t and number)		9b.	CITY, TOWN	OR LOCATION OF DE		: 3, 1		MAI OF DE	yland	
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읝	Northwest Hospital	Center		1	kandal	1stown_			Ва	ltimo	re	
DIRECTOR	10a, STATE 10b, COUNTY			10c. CITY, TO	WN OR LOCAT	TION					10d. INSIDE CITY	
ā	Maryland Balti								LIMITS?	NO		
A	10e. STREET AND NUMBER	10f. ZIP CODE 10g. CITIZEN OF WHAT COU								-		
10e. STREET AND NUMBER 3010 N. Rolling Road 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNT U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 VES 2 NO 11. Marriad 12. Was Decembert of Hispanic Origin? (Specify Ves or No- 14. RACE — American Black, White, etc. 15. Was Decembert of Hispanic Origin? (Specify Ves or No- 16. RACE — American Black, White, etc.												
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American						- American India	in.					
	1 Never Married 2 Married	FORCES? 1 [10	If yes, sp 1 ☐ YES	ecity Cuban, Mexica 2 A NO Specifi	m, Puerto F	lican, stc.)		Black, Specify	White, etc.	
BY	3 🕅 Widowed 4 🗌 Divorced									apeun	White	
	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION noietecti	16a. DE	CEDENT'S USU	AL OCCUPATION	ON	16b.	KIND OF BUS	INESS/IND	USTRY		
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MP	7th Grade		Hot	usewife	2			Own Ho	me			
COMPLETED	17. FATHER'S NAME (First, Micidle, Last)					18. MOTHER'S NA	ME (First, A	fiddle, Maiden	Sumame)			
BE (Louis Uebel					Kather:	ine K	roner				,
9	19a. INFORMANT'S NAME (Type/Print)		19t	. MAILING AOO	RESS (Street a	nd Number or Rural I	Route Numb	er, City or Town	n, State, Zip	Code)		
F	Mrs. Doris Wilson		(6805 Au	itumn '	View Dri	ve S	vkesv:	ille.	MD	21784	
	20a. METHOD OF DISPOSITION 1 A Burial 2 Cremetton 3 Remova	I from Chate	20b. PLACE A	NO DATE OF DIS	SPOSITION (Na	me of	DATE		CATION -			
	4 Donetion 5 D Other (Specify)		Lorra	netory or other p	k Cem	etery	10/1	18/95	Wood	lawn.	Maryla	nd
	21. SIGNATURE OF TUNERAL SERVICE LICEN	SEE			22, NAME AN	ID ADORESS OF FA	CILITY					-
	DE NOTE OF THE PROPERTY OF THE					g Byers 1						
	#3. PART i. Enter the diseeses, or com	polications that ca	used the de-	eth Do not e	8728	Liberty I	Road	Randa	allst	own.		133
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H	IMMEDIATE CAUSE Final	A	WITS	my	TAR	DIAL	In	FAR	CT	ION	Onset and	Death
	resulting in death) a		AS A CONSEC								301	1/5
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DICAL	PART II. Other aignificent conditions of	ontributing to dea	ith but not re	eauiting in the	e underlying	cause given in	Part I.	24s. WAS AN			WERE AUTOPSY FIR	
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	4 Homicide detarmined		(City	or Town, State)				
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAI	N: To the best of my	knowledge, des	th occurred at 1	the time date	and place, and due	to the cour	anda) and man		4		
Ž	one) 2 MEDICAL EXAMINER: C										and manner es et	nted .
1.0	29b. SIGNATURE AND TITLE OF CERTIFIER								_			
B	The State of Centifier	1	01	7		29c. LICENSE NUM	BER C	3	29d. DATE	SIGNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMBI ETER CAUSE -		00		0000		-	P 10	17	77	
	FRANCIS	KH07)	P DEATH (ITEM	RTHIA	CEST	D 303	21	ENT	ER			
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m	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funerate filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical exami
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH October 16, 1995" Hatton, Sr. 0703 Russell Leo 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Feb. 16, HOURS 1 M 2 - F 578-01-6673 82 1913 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c COUNTY OF DEATH DIRECTOR Calvert Memorial Hospital Prince Frederick Calvert RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Fort Washington 1 YES 2 XNO 10a. STREET AND NUMBE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3819 Lumar Drive 20744 U. S. of A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2XXNO Specify: BY 3 2 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 8 Mechanic U. S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) T Richard Dixie Hatton 8 Sarah Jane Wignall notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Shirley L. Scott 3905 Plum Point Road, Huntingtown, Md. ě 20a. METHOD OF DISPOSITION

1 String Burlel 2 Cremetion 3 Red
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Oct. 19, OATE 20c. LOCATION -- City or Town, State must Washington Nat. Cemetery 1995 Suitland, Maryland examiner 21. SIGNATURE OF FUNDMAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, Md. event, the medical 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Finei disease or condition resulting in death) inte shows any injury, or other traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Lesmaton 1 TYES 2 NO Orpon num 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO OTHER: 1 Inpetient 2 ER/Outpatient 3 I DOA 4 Nursing Home S Residence S Other (Specify) 0 27. MANNER OF OEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 2 Accident 5 Pending investigation 1 YES 2 NO BY 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28 ls 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, 8 D 27 189 10/16/91 Jonson 2 30. NAME AND ADDRESS OF PERSON WNO DOMPLETED CAUSE OF DEATH NIEM 27) (Type, Print)

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32 REGISTRAR'S SIGNATURE

		1 - FOR STATE REGISTRAR	STATE OF MARY	YLAND / DEPAR CERTIF	TMENT OF H	IEALTH AND		HYGIENE REG. NO.		1040
		DECEDENT'S NAME (First, Middle, Last) ERIC Je	rome	HUG	ernes seri		2. DATE OF			TIME OF DEATH
무		4. SOCIAL SECURITY NUMBER 216-36-1970	5. SEX 6. AC	SE (In yrs. lest birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MHI.	7. DATE OF (Month, D	ВІЯТИ	B. BIRTHPL Country)	ACE (State or Foreign
2, 3 should	CTOR	9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, Maryland 9c. COUNTY OF DEAT Baltimon								
nit. Pages 1,	DIRE	MANUTANO RESIDENCE OF DECEDENT 106. STATE 106. COUNTY	N/A.	10c. CIT	Y, TOWN OR LOCAT	TION RC	2)			Od. INSIDE CITY LIMITS? ZE YES 2 \(\text{NO}\) NO
an. Iransit permit.	FUNERAL	100. STREET AND NUMBER	Aver		101	2/2/	7	10g. CITIZ	N OF WH	AT COUNTRY?
5-0020 nding physician. s the burlal-fransit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 NO	If yes, sp	ENDENT OF HISPA ecity Cuban, Maxic 2 PNO Speci	an, Puerto Rica	Specify Yes or No— n, etc.)	A. RACE Black, V Specify	- American Indian, White, atc.
	ETED.	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION work done during more retired.)	ON st of working	16b. Kil	ND OF BUSINESS/INDU	STRY	0
E LIK	COMPL	17. FATHER'S NAME (First, Middle, Last)	0	14	boreR	18. MOTHER'S N	AME (FIRE MICO	OCTORA	nd C	amble
MARY retained to 5 shou notifie	#	Da. INFORMANT'S NAME (Typo/Print)	New	HILEN 19b. MAILING	ADDRESS (Ştroot a	VIVIA	y Ron	naine	Le c	beller
P Pe Pe	12	M'5 Acqueling 200. METHOD OF DISPOSITION	. Hugh	S 808	whex	ington	5%	BAlto.	mo	1,21201
E e e		1 Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State	certatery crematory or o	mount	Cem	19/18	BAITIN	107-E	Smd.
SAL r death we fune al.		Joseph.	1. Rus	2	bsep	h L. Fl	th A	ve, BALI	5,5	121216
filled in by for, or remo		23. PART I. Enter the diseases, or cahock, or heart failure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	liat only one ceuse or	sed the deeth. Do not be seen line.		de of dying, au	ch as cardiac	or reapiratory arre	at,	Approximata interval Between Onset and Death 48 HOURS
D 0 7 6	z		DUE TO (OR A	S A CONSEQUENCE OF	F):					
S ior is	CATIO	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF):							
ending	ERTIFICATION	that Initiated eventa resulting in death) LAST	DUE TO (OR AS	DR AS A CONSEQUENCE OF):						
0 6 5 4	CAL C	PART II. Other algnificent conditions HYPERTENSION	contributing to deeth	but not resulting i	in the underlying	g cause given in	Part I. 24	. WAS AN AUTOPSY PERFORMED?	Al	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
w requires that the been signed by the of Health and shows any in	MEDIC	ALCOHOLISM					_ 1	YES 2 NO	OI	OMPLETION OF CAUSE F DEATH?
AL has b Dept.	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH YE	M (Check only one)] UNCERTAI	N 🗆			
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DING PHYS After this of death with marked,	B	V Natural 5 Pending 2 Accident Investigation 3 Suicide S Could not be	(Month, Day, Year	// INJ	M 1 🗆 Y	RK? /ES 2 NO		N (Street and Number o		
OR ATTENDING DIRECTOR: After hours after death ltem 28 is ma	ETED	4 Homicide determined	building, etc. (S	pecify)			City or K	own, State)		e Number,
	COMPLE	000) 2 MEDICAL EXAMINER	IAN: To the best of my kn							nd manner as stated.
HE HE S W 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICE						29c, LICENSE NU D 46673			SIGNED (M	onth, Day, Year)
		ANTHONY H. GUARII	NO, M.D. 726	O YORK RO		SON, MA	RYLAND	21204		
8		OCT 1 8 1995	32 ANGGISTALES SI	PHATURENCE H						

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completely filled in by the funeral director, page 5 should be detached for use as the burial-transit

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State certificate

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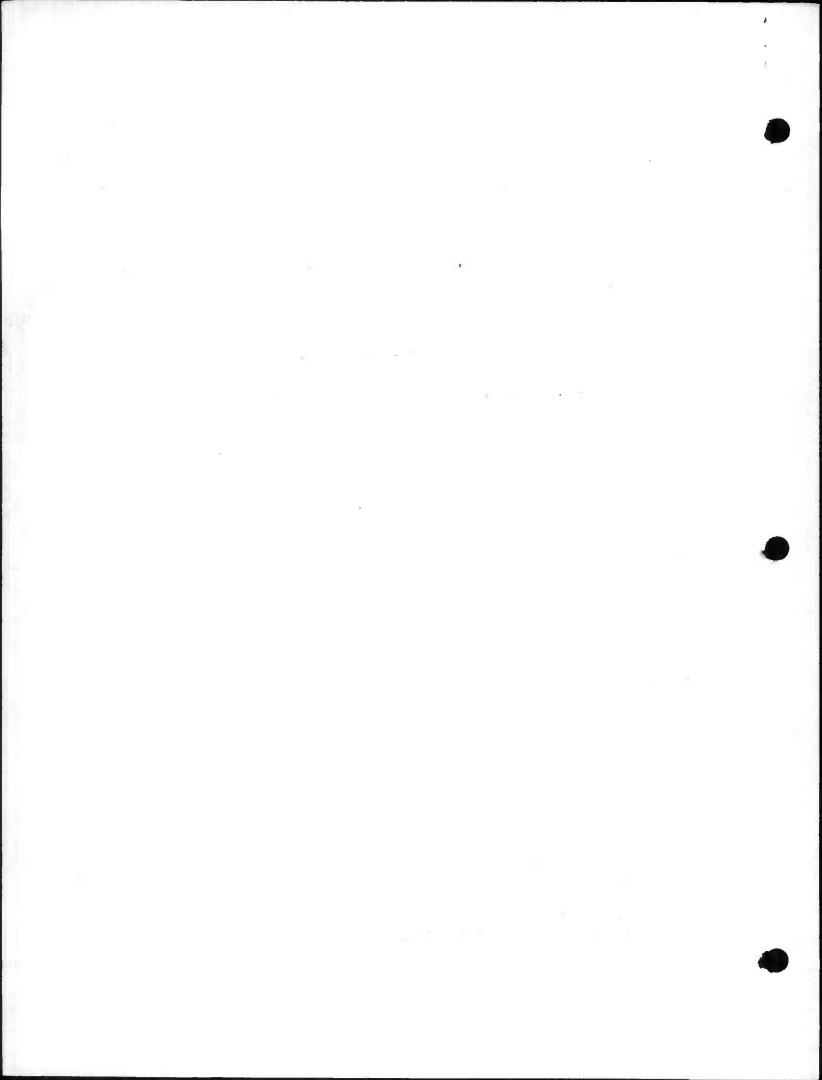
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 9:16 A. Tina Haney October 13,1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 F 233-30-6425 West Virginia 90 2-7-1905 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dulaney Towson Nursing Center Towson Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Towson t TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WNAT COUNTRY? 101. ZIP CODE 2 Southerly Court Apt 207 21286 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Merried Specify: White 1 YES 2 NO Specify: 3 Widowed 4 Divorced BY ETED. 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life, Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPL 12 Engineering Westinghouse Electric Dept. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Raymond Curtis Kelley Janette Viola Dent 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mildred H. Murray Same As #10 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Buriel 2 Cremation 3 Removal from State Donetion 5 Other (Specify) Dulaney Valley Mem. Gards 10-16-95 Timonium, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY · Wallace S. B. Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximats Interval Batween Onset and Dasth IMMEDIATE CAUSE (Final demented disesse or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEQ? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO de COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🔀 PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 M Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER

// hack onto

// CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the besie of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner se stated. 296. NGNATURE AND TITLE OF CERTIFIEM 29d. DATE SIGNED (Month, Day, Year)

10/16/95 29¢ LICENSE NUMBER BE D26391 larcia ane my 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Marsha Kane 301 St. Paul St. Suite 403 32 HEGISTRA'S SIGNATURE



9c. COUNTY OF DEATH

Carroll

10s. CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATH

7:05

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

Approximate

24b. WERE AUTOPSY FINDINGS

OF DEATH? 1 YES 2 NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE

interval Between

Onaet and Death

ZWEEKS

1 YES 2 NO

8. BIRTHPLACE (State or Foreign

Maryland

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

	hours
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20	within
. BOX 68760	executed within 24 ho
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P.O. B(certificate
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5	ITTENDING PHYSICIAN: 7
DIVISION	ATTENDING
5	OR
	PITAL OR A

Lillian Gertrude Heintzman Oct. 16 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Month, Day, Year) 1908 1 M 2 XF HOURS 216-56-3235 Aug. 87 YRS should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Westminster Nursing & Convales. Ctr. permit. Pages 1, 2, 3 Westminster RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY Baltimore Md. Borina FUNERAL 10a. STREET AND NUMBER filled in by the funeral director, page 5 should be detached for use as the burial-transit on, or removal. 14813 Old Hanover Road 21020 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THOU IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)
 T YES 2 NO Specify: 11. MARITAL STATUS 1 Never Married 2 Married BY 3 🕅 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kihd of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Homemaker 8 Own home. 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname notified at Jacob Sauble Emma Akehurst BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 Evelyn M. Peltzer 14823 Old Hanover Rd. Boring. Md. ě 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Pleasant Grove Cemetery □ Donation 5 □ Other (Specify) Boring, Md. 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Road examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE after death. Sams Eline Funeral Home Reisterstown, Md. 21136 ine medical 23. PART I. Enter the diseasea, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, ahock, or heart failure. List only one cause on each line. 0 **IMMEDIATE CAUSE (Final** the cremation, disease or condition_ NEUMONITIS (TERMINAL) completely resulting in death) or other traumatic event, and com CERTIFICATION Sequentielly list conditions, prior to t DUE TO (DR AS A CONSEQUENCE DF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST the attent Item 23 shows any injury, PART II. Other aignificant conditions contributing to deetb but not reaulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Signed by the Health and I 1 TES 2 (NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check gary one) certificate h **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO 1 | Inpetiant 2 | ER/Outpetient 3 | DOA Home 5 - Realdence 6 - Other (Specify) 0 the 27. MANNED OF DEATH 28a. DATE OF INJURY this c with t 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED hours after death with t item 28 is marked, t Netural M 1 YES 2 NO В After death 2 Accident Investigation 28s. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. THE HOSPITAL (
THE FUNERAL O
filed within 72 h
PORTANT: If IN TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the

32. REGISTRAR'S

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

stion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

29c. LICENSE

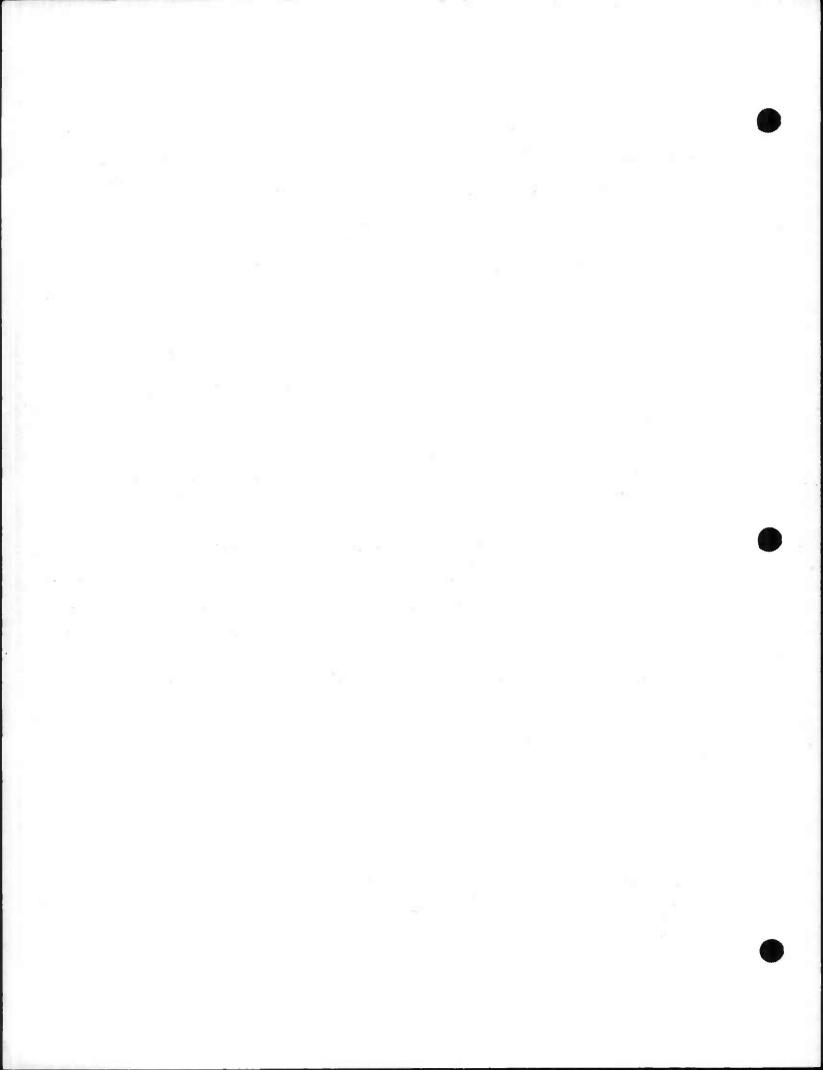
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	TMENT OF	HEALTH AND	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY)	YEAR 3.	TIME OF DEAT	'n	
•			STER RICHARD IAMMARINO OCT 15 19									
		The second secon	5. SEX 6. AGE (In y	rs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTN (Month, Day, Year)	8.	. BIRTNPLA Country)	VCE (State or For	reign	
9		277-12-0786 9e. FACILITY NAME (If not institution, give stre		YRS.			SEAT 8	1914		HIO		
, 2, 3 should	DIRECTOR	GOOD SAMARITA RESIDENCE OF DECEDENT				LTIMOR		9c. COUNT	A DEATH	A		
pes 1	<u> </u>	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION			104	d. INSIDE CITY		
permit. Pages		MD. BAL	TIMORE		PARK	VILLE			1{	LIMITS?	NO	
E	FUNERAL	10e. STREET AND NUMBER				O1. ZIP CODE		10g. CITIZE	N OF WHAT	T COUNTRY?		
physician. burial-transit	買	1744 WENTWO				212:			0.5	. A.		
physician burial-tra	5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES	NO NO	13. WAS DE	ECENDENT OF NISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	e or No 14	6. RACE -	American India hite, etc.	in,	
	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE		1 🗆 YE	S 2 NO Specif	y:		Specify:	111		
r attending use as the	ED	15. DECEDENT'S EDUCA	TION 16	a. DECEDENT'S	USUAL OCCUPAT		16b, KIND OF BU	ISINESS/INDUS	STRY	JHITE	<u></u>	
2 2		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during n se retired.)	nost of working						
Spit	P P	12 yrs	2 425	Com	PUTER	OPERATO	OR B	ALLRO	CAC			
o de de	COMPLE	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Melder	Sumame)				
ad be	BE	ANGELD TAM	MARINO			ASSU	NTA MI	NADE	EO			
5 should	욘	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING			Route Number, City or Tov	vn, State, Zip Co	ode)	2123	4	
ay be re page 5			MARINO	1744		WORTH	ANE F	ARKV	ILLE	- 100	_	
	18	20e, METHOD OF DISPOSITION 1 D. Burlel 2 Cremation 3 Remov	al from State cemeter	v, crematory or o	OF DISPOSITION (I	Name of	10-1	CATION - CIT		00-		
w E	- 3	4 Donation 5 Other (Specify)	HORE 4 TO	ARKW		AND ADDRESS OF FA	16	PRKU	ILLE	- 1 16	7	
death. Page 6 m funeral director,		1300	00			45 CHAP		EMORY	ES			
0 = 0		23. PART I. Biter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate										
3		23. PART I. Byter the diseases, or commonly of the state	mplications@Mit caused that only one cause on each	e death. Do r illne.	not enter the m	ode of dying, suc	h as cardiec or resp	iratory arrea	t,	Approxima Interval Be		
10 mg		IMMEDIATE CAUSE (Final disease or condition	0000 (2						Onset and		
completely fills tal, cremation, event, the		resulting in death)	CARDIO F	ULM	ONAL	24 A	RREST			5m	m	
P . P	_		PCO 1 THE THE		,.					Vo		
8 0 5	ō l	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO					_				
	3		PERIPERA DUE TO (OR AS A CO	ta V	ASCU	LBA	DISEASE YA					
nding phy Hygiene p	E	The state of the s			F):							
E H	CERTIFICATION	resulting in death) LAST	CORONO	ry	ANTE	Ry D	ISEASE			YRS		
e 88 5	0	PART II. Other significent conditions	contributing to death but	not resulting	In the underlyic	ng ceuse given in	Part I. 24s. WAS AN	AUTOPSY	24b. WEI	RE AUTOPSY FIN	NDINGS	
that the photographic photograp	2	NICOTINE	DEPR				PERFO		AMA	ILABLE PRIOR T	TO	
requires that been signed b or Health ar shows any	MEDIC				1		1 _ YES :	z gonu		DEATH?	in	
× 0 ×		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF I	DEATH YE	S NO [UNCERTAI	NO		'] 120 Z [] N	_	
- # 2 R	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. HOSPITAL:	PLACE OF DEAT	TN (Check only one)						
ician: ertifica the Str	YSI	1 TES 2 10 NO 1	☐ Inpatient 2 ☐ ER/Outpatie	nt 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 - Residence	8 Other (Specify)					
this ce with t	표	27. MANNER OF DEATN 1 Maturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY W	JURY AT ORK?	28d. DEŞCRIBE HOW	INJURY OCCUP	RED			
	BY	2 Accident Investigation				YES 2 NO						
TTENO TOR: A after d	G	3 Suicide 8 Could not be 4 Homicide determined	26s. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s	street, factory, offi	Ice	281. LOCATION (Street City or Town, State)	and Number or	Rural Route	Number,		
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State I them 28 is marked, or Item	Ш	29e. CERTIFIER										
TAN TAN	COMPL	(Check only 1 DE CERTIFYING PHYSICI)	AN: To the best of my knowledg On the basis of examination an									
HOSPITAL FUNERAL WITHIN 72	8		On the basis of examination an	Wor investigatio	n, in my opinion,						ated.	
TO THE HOSPI TO THE FUNES be filed within IMPORTANT:	BE	286. SIGNAPOTHE AND TITLE OF CENTIFIER	201	PC	11.	29c. LICENSE NUI	WER	29d. DATE S	IGNED (Mor	nth, Day, Year)	,]	
2 2 3 2	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) /5	Print)	11/86	556	0	ct1	8,18	90	
		RICHMON U	VARRELI	R.	TRIC	1 8	ALTO	m	2	1230	4	
		31. DATE FILED (Mook), Day (bar)	3 REGISTRAR'S GN TU	TE -DI/	1144	010	0 177474	PRI	K	MD!		
		UCI I 01995 Jah	A CHEMORECE AND A	-								



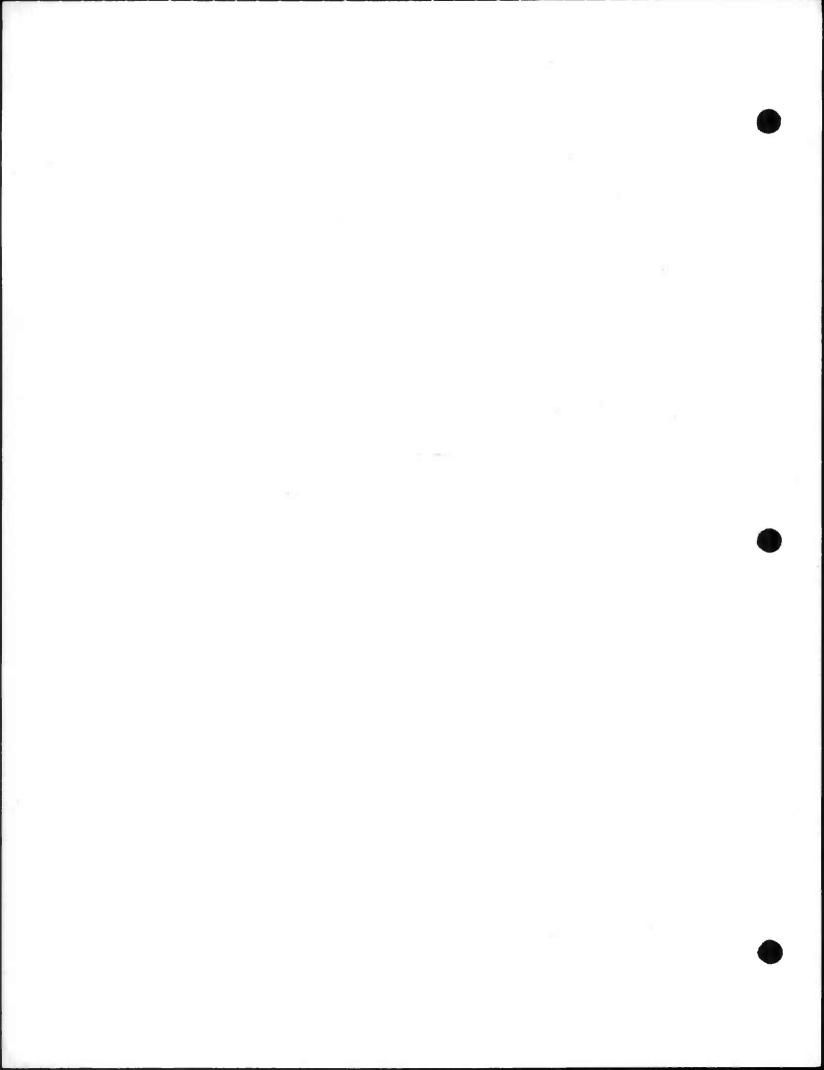
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTING	MENT OF HI	EALTH AND DEATH	MENTAL HYG					
	1. DECEDENT'S NAME (First, Middle, Last)	Irene	- Joh	IKM		2. DATE OF DEAT	H DAY Y	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 216-23-3940 1 M 2 F B 2 YRS. 6. AGE (In yrs. last birthday) 1 UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Year) 1 M 2 F B 2 YRS. NONTHS DAYS HOURS MIN. WAY. 21 1978 Mary (PND)										
TOR	90. FACILITY NAME (If not institution, give street and number) METIDIAN UURSING Center- Breen Ballimore Boc. COUNTY OF DEATH RESIDENCE OF DECEDENT										
DIRECTOR	The second secon										
FUNERAL	6225 Wal	Read Auc	NUE	10f.	ZIP CODE	-12_	10g. CITIZEI	1 NYES 2 □ NO N OF WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Diverced	12. WAS DECEDENT EVER IN FORCES? 1 VES IF YES, GIVE WAR OR DO	1 7MO	II yes, spec		NIC ORIGIN? (Specifien, Puerto Rican, etc.)		Black, White, etc.			
	16. DECEDENT'S EDU (Specify only highest grade		18a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during most	of working		BUSINESS/INDUS	1			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)	Parsu	tactor	400	OF ICE T	ME (First, Middle, Me	iden Surname)	orporation			
TO BE	196_INFORMANT'S NAME (Type/Polit)	Berry	19b. MAILING AD			Route Number, City of	1011	14M2 W			
	20s METHOD OF DISPOSITION Burlel 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from State	PLACE AND DATE OF D		HINGTUI	10 177/93	TOCATION - CITY	Lis Marylanso			
	21. SIGNATURE OF FUNERAL SERVICE LI	cephyles Te	DERHILL	The state of the s	ADDRESSTOF FA	COLITY 53 Y	U REIST	pariwa Faro			
	Juny 9	ahris		CHATI	man-1	lams F.	H. Bal	timere helses			
	23. PART I. Enter the dispess, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition	complications that caused List only one cause on a	ach ilne,					Interval Between			
	rasulting in death)	/	CONSEDUENCE OF):	berotic	(and,	overal	a dise	3 rust			
CATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEDUENCE OF):										
RTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		CONSEQUENCE OF):	ascula	_ dise	ase		, Fust			
L CE	PART II. Other significent condition	e contributing to death b	ut not resulting in t	he underlying	ceuse given in	Part I. 24s. W65	S AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
MEDICA						PEF	S 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIL	N 🗆		1 TES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		тная:	£ ☐ Daeldense	6 Other (Specify)					
PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. INJUI WOR	RY AT A	28d. DESCRIBE HO	OW INJURY OCCUR	(ED			
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, stree		S 2 ND	7	reet and Number or	Rural Route Number,			
COMPLEIED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowl	edge, death occurred at	t the Ilms, date e	nd place, end dua	to the cadacia) and	manner as stated.				
200	One) 2 MEDICAL EXAMINE	R: On the basis of examination									
mre 16(22 0 100 10 10 10 10 10 10 10 10 10 10 10								IGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Prin					1 10			
	31. DATE FILED (MONTH, Day, Year) 1995					···					

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permit. Pages 1, 2, 3 should

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DIRECTOR

FUNERAL

BY

COMPLETED

BE notified

9

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by		
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The law	ste has	ate Dept	ет 23
SICIAN	certifica	h the St	d, or 11
ING PHY	ofter this	eath with	marke
ATTEND	ECTOR: A	s after d	1 28 is
TAL OR	TAL DIRE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPI	E FUNER	d within	RTANT
TH OT	HI O	be file	IMPO

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATH JOHNSON YEAR MAL N 10 1245A 95 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 1/16/1953 IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 8. BIRTHPLACE (State or Foreign DAYS 216-58-2352 1 M 27 F 42 Balto., 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 3414 Park Heights Ave. (res.) N/A Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 YES 2 | NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3414 Park Heights Avenue 21215 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE -- American Indian, Black, White, etc. 1 Never Married 2 1 Married 1 YES 2 NO Specify Specify: 3 Widowed 4 Divorced Black 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Nursing Assistant 11th 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Odell Price Mary Holden 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Tisdale 3414 Park Heikghts Ave., Balto., MD 21215 20a. METHOD OF DISPOSITION
1 □ Burial 2 🛣 Cremetion 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Crematory 4 Donallon 5 Other (Specify) Baltimore, MARYLAND 10/21 21. SIGNATURE OF FUNERAL SERVICE LICES 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 23 Part Inter the diseases or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory strest, stock, or hear fallers. List only one cause on such line. Interval Between IMMEDIATE CAUSE (Final Onset and Death UNG CANCER disease or condition resulting in dasth) 18 months DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, OUF TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 700 OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Noma 5 (Ranidence 8 Other (Specify) 27. MANNER OF OEATN 28c. INJURY AT WORK?
1 YES 2 NO 28a. OATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED (Month, Day, Year) 1 Natural Pending 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 4 Nomicide datarmined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITCE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

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IN THE MOST INC. OF ALLICONIST. THE PRINCIPLE OF THE PRIN	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2,	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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B.K.S FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH OCT . 1 3. TIME OF DEATH 1995 GERALD DUANE **JOHNSON** 1349 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign June 13,196 (Michigan 1 M 2 - F 35 374-74-4819 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 2027 CRESTVIEW AVENUE N/A BALTIMORE CITY RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 XYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP COOF 10g. CITIZEN OF WNAT COUNTRY? 2027 Crestview N/A USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced Black ETED. 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only hig Elementery/Secondary (0-12) College (1-4 or 5+) COMPL Clerk IRS 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Melden Surneme) Harold W. Johnson Sr. Betty Moore BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Betty J. Johnson 21930 Stratford Ave. Oak Park, Mich 48237 20b. PLACE ANO DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Competery, cromatory or other place) Cemetery 10-21 Detroit, Mich. 22. NAME AND AODRESS OF FACILITY
Douglass Funeral Service 21. SIGNATURE OF FUNERAL SERVICE LICENSE! e ton 1701 McCulloh St. 23. PART I. Enter the diseases, or complications that could the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Fins) disease or condition . STRANGULATION & MULTIPLE STAB WOUMPS resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART if. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAIL ARK F PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 1 NES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL OTHER: 1 X YES 2 | NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. MANNER OF OFATN 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending 1 YES 2 NO SUBJECT BY 2 Accident 281. LOCATION (Street and Number or Rural Route Nur City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Nomicide 2017 CRESTULEW RP BAUTIMOR HOME 29e. CERTIFIER

(Chack only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee stated. (Check only one) 2 X MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner se stated.

SIGNATURE AND TITLE OF CEA 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Golfo OR M(1)1 Penn Street, Baltimore, Maryland 21201

O.C.M.E

31. OATE FILEO (Month, Day, Yber) 32. REGISTRAR'S SIGNATURE drude

DHMH-16 Rev 1/89

▶OCT. 12,1995

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

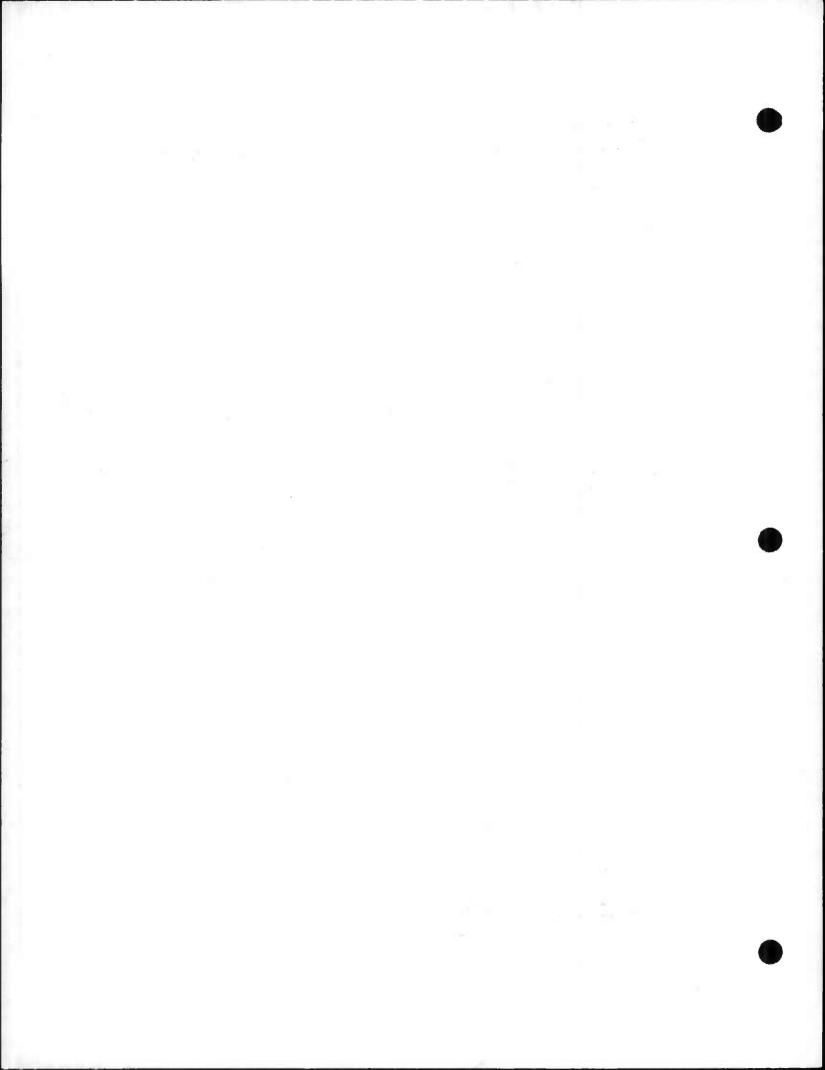
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICATE	OF D	DEATH	P	REG. NO.	-			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATN		WELL	3. TIME OF DEATN	
		4. THomas					Ocho	Can "		1995	9:10 Am	
	4. SOCIAL SECURITY NUMBER 034-07-2994		(In yrs. last birthday			IF UNDER 24 HRS.	7. DATE OF I	DATE	909	Country	PLACE (State or Foreign y) Sachusettes	
NC.	Bis. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF OEA										EATN County	
5	Howard County Go	eneral nosp							110	ward	Courtey	
DIRECTOR	Maryland Howard County Ellicott City									10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	3000 North Ridge		10f. ZIP COOE 21043					10g. CITIZEN OF WHAT COUNTRY? USA				
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 XMdowed 4 Divorced	12. WAS OECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	If y	yes, specif	DENT OF NISPAI fy Cuben, Mexica NO Specif	n, Puerto Ricar	pecify Yes n, etc.)	or No-	Black	- American Indian, White, etc.	
	15. DECEOENT'S EDUC (Specify only highest grade of		16a. DECEDENT	S USUAL OCC	CUPATION	of working	16b, KJN	D OF BUS	BINESS/IN	IDUSTRY		
COMPLETED	Elementary/Secondary (0-12) Un]KNOWI	College (1-4 or 5 +)	homem	use retired.)			own	home	9			
™	17. FATNER'S NAME (First, Middle, Last)				1	6. MOTNER'S NA	ME (First, Middl	le, Maiden	Surname)			
BEO		is Braica					s Mang					
2	Mr. John E. Thomas	s, Jr.	19b. MAILIN 1,2030-	O ADDRESS (S A Little	Street and Pata	Number or Aural UXENT Pai	Houte Number C	blumb	n. State, Z	h com) farylar	nd 21044	
	20a. METNOD OF DISPOSITION Commetted											
	22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. MOOF 25. Ellicott City Maryland 21042											
-	22 DAFT I Enter the diseases a complication that											
	Interval Between IMMEDIATE CAUSE (Final disease or condition IMMEDIATE CAUSE (Final Description)											
	resulting in death) Due to (or as a consequence of):										years	
NO	Sequentially list conditions, Due to (or as a consequence of):											
CAT	If any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	that initiated eventa resulting in death) LAST	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
	PART II. Other significant conditions	contributing to death	but not resulting	In the unde	erlying c	ause given in	Part J 24e	. WAS AN	AUTOPSY	246	WERE AUTOPSY FINDINGS	
EDICAL							- 1	PERFOR	MED?	240.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
≥	DID TOBACCO USE CONTR	BUTE TO CAUSE (DE DEATH V	ES DINI		LINICEDTAI					1 YES 2 NO	
Ä	25. WAS CASE REFERRED TO MEDICAL	DOTE TO CAUSE (26. PLACE OF DE			UNCERIAII	<u> </u>					
) S	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	patient 3 DOA	OTHER:	g Nome	5 Rasidence	6 Other (Sp	ecify)				
BY PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. Ti	JURY	Bc. INJURY WORK	Y AT	28d. DESCRIE	BE NOW IN	NJURY O	CCURED		
	2 Accident arresingation								and Number or Rural Route Number,			
COMPLETED		IAN: To the beat of my know										
Š Į	one) 2 MEDICAL EXAMINER	On the basis of examination	on and/or investigat	on, in my opin	nion, deati	h occured at the	time, data and	placa, and	d dua to t	he cause(a)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29	C. LICENSE NUM	MBER		29d. DA	TE SIONED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O	EATN (ITEM OF CT	a Defeat)		250	825		P C	/c/06	11 1785	
	JESS Z LEVI- 31. OCT I "8 1995" Jah	12, 11053	- Little	Arrek	al	PG	, Cal	Com (صحد	mal	21044	
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	1 - FOR STATE REGISTRAR	OF MARYLA	ND / DEPAR				MEN	ITAL HYGIENE REG. NO.				
ì	1. OECEOENT'S NAME (First, Middle, Last) PATRICK B. KIRWAN						N	DATE OF DEATH DAY DON'TH DAY	6 10	YEAR	3. TIME OF DEATN	
		5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE (8:20 A. M	
	212-05-2227 1 K M 2	□	YRS.	MONTHS	DAYS HO	URS MIN.	Ai	JG • 25 • 190	LAND			
H.	ST. ELIZABETH S NURSIN				LTIMO	OCATION OF I	DEATH			TIMO		
DIRECTO	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		400 00	TY. TOWN O	1 OCATION						tod. INSIDE CITY	
	MARYLAND HOWARD		100, 011	,		T CITY	7			-	LIMITS?	
	10e. STREET AND NUMBER		EL.	10f. ZIP				10o. CITI	HAT COUNTRY?			
H.	4016 OLD COLUMBIA PIKE				-	043		- 1		.A.		
FUNERAL	11. MARITAL STATUS 12. WAS DE	CEDENT EVER IN	U.S. ARMED		AS DECEND	ENT OF NISP		RIGIN? (Specify Yes			— American Indian, , White, atc.	
BY FI		7 1 YES				Cubsn, Mexi XNO Spec		erto Rican, atc.)		Specif		
	15. DECEDENT'S EDUCATION		16a. DECEDENT'S	S USUAL OC	CUPATION	t		16b. KIND OF BUSI	NESS/INC	DUSTRY		
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4 or 5 +)	(Give kind of life. Do NOT u	use retired.)	uning most or	working						
릴	12TH GRADE		SUPER	INTEN	DENT			BALTIM	ORE			
် ဂ	17. FATHER'S NAME (First, Middle, Lest)				16.			First, Middle, Maiden S				
BE	PATRICK KIRWAN				- 1			IZABETH E				
2	190. INFORMANT'S NAME (Type/Print) MR. AUGUSTUS S. WURTZE	R						Number, City or Town, - ELLICOT			D 21043	
	20g. METHOD OF DISPOSITION 1 X Buriei 2 Cremetion 3 Removat from St		PLACE AND DATE					OATE 20c. LOC	ATION —	City or To	wn, State	
	4 Donation 8 Other (Specify)	LOI	RRAINE	_					TIMO	RE		
	21, SIGNATURE OF FUNERAL SERVICE LICENSEE	llan	non	HU	BBARD		RAL	HOME, IN ENUE-BALT		E M	D 21229	
\dashv	23. PARTA Enter the diseases, or complication	ns that caused	the death. Do				_				Approximate	
	ahock, or heart failure. List only o	na cause on aa	ch lina.								Interval Between Onset and Death	
	IMMEDIATE CAUSE (Final disease or condition										day	
	resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
z l	Sequentially list conditions, DUE TO (OR AS A COMPROMENCE OF):											
	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE (OF):								
2	CAUSE (Disease or Injury C.	DUE TO (OR AS A	CONSEQUENCE	OFI:			7					
CERTIFICATION	that initiated events resulting in death) LAST			/-								
S	d											
ZAL.	PART II. Other algnificant conditions contributed	_	it not reaulting	In the un	derlying c	ause given	In Pari	t I. 24s. WAS AN A PERFORI		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
EDIC	arterioscleratio	coron	ary d	luce	عبو			1 YES 2	NO		OF DEATH?	
M	multistroked	lema	utia		_			_			1 TYES 2 NO	
N.	DID TOBACCO USE CONTRIBUTE TO		F DEATH Y			UNCERTA	AIN L					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	AL:		OTHER	1:							
IXS		ATE OF INJURY	rtient 3 □ DOA		ing Nome :		-	d. DESCRIBE HOW IN	IIIBY OC	CHBED		
	1 Natural 5 Pending	Aonth, Day, Year)		NJURY	WORK							
BY	2 Accident investigation 3 Suicide a Could not be	LACE OF INJURY	— At home, ferm	, street, fact		- 1	281	t, LOCATION (Street as	nd Numbe	r or Rural F	Route Number,	
딢	3 Suicide a Could not be 4 Homicide determined	uliding, atc. (Speci	ify)					City or Town, State)		Managa .		
COMPLET	29e. CERTIFIER t CERTIFYING PHYSICIAN: To the	beat of my knowle	adge, death occu	rred at the t	me, date end	d piece, end c	fue to t	he ceuse(s) end men	ner en ata	rted.		
ME	(Check only one) 2 MEDICAL EXAMINER: On the ba	sis of examination	end/or investigat	tion, in my o	pinion, deati	h occured at t	the time	e, date end place, and	due to t	he ceuse(s	s) and manner as stated.	
	291 SIGNATURE AND TITLE OF CERTIFIER				29	9c. LICENSE P	NUMBER	R .	29d. DA1	TE SIGNED	(Month, Day, Year)	
BE	Naurence R ga	llage	2,14	0	Li Li	00	17	86	► C	CT	16,1995	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLET	ED CAUSE OF DEA	ATH (ITEM 27) (Typ	pe, Print)								
		ER - 34	55 WILK	ENS A	VENUE	- SUI	LTE	300 - BA	LTO.	, MD	212229	
		GISTRAR'S SIGNA										
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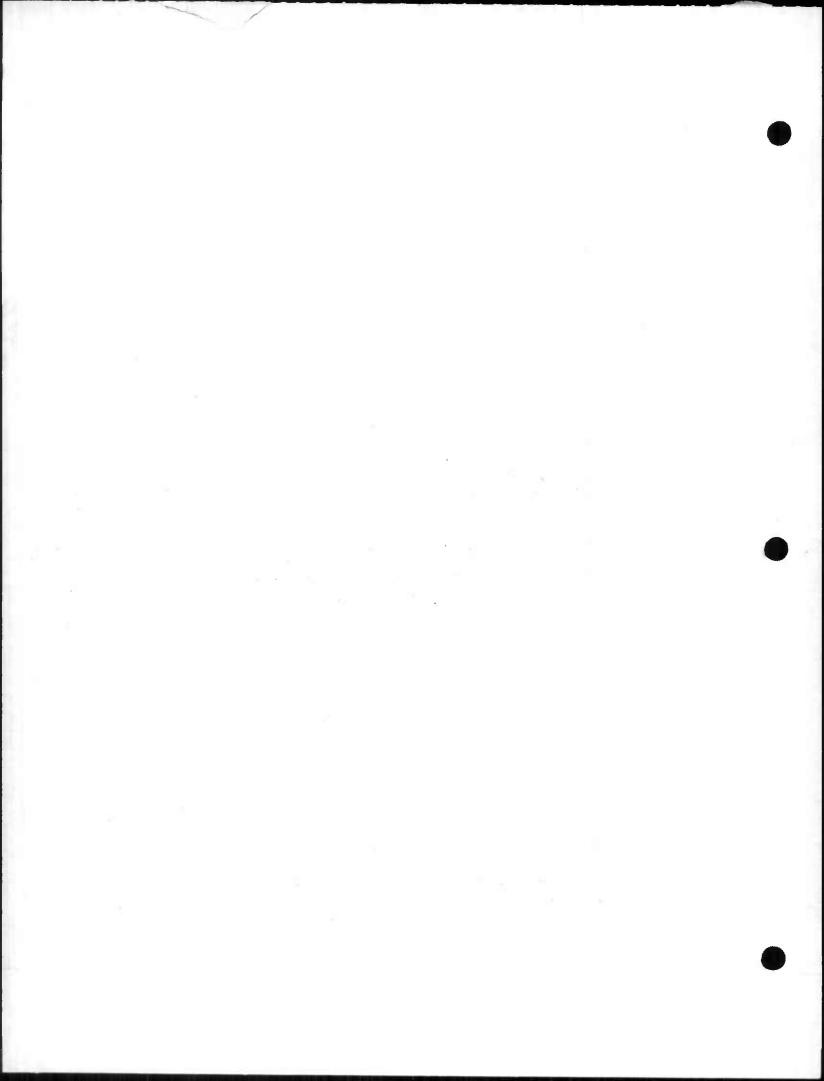
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	tificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
acuted within 24 hours after death	ind completely filled in by the fune	burial, cremation, or removal.	atic event, the medical exam
res that the death certificate be ex-	igned by the attending physician a	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ws any injury, or other traum:
IDING PHYSICIAN: The law requir	s cer	death with the State Dept. of H	s marked, or Item 23 show
TO THE HOSPITAL OR ATTEN	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with t	IMPORTANT: If item 28 is marked,

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR				CHILIF	IUMII	COF	DEA	III.		HEG. NO			
	. 1. DECEDENT'S NAME (First, Middie, Lest) MELVIN D. KEIL									2. DATE OF DEATN MONTH DAY YEAR 3. TIME OF DEATN				
- 1	4. SOCIAL SECURITY NUMB		5. SEX 6. AGE (In yrs. last birtho			y) IF UNDER 1 YEAR IF UNDER 24 HRS.				OCTOBER 14, 1995				9:45 P. M
	219-18-2897	en .	1 XM 2 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	Worth, Day, Year) Y 11,1926 MARYLA			
	9a. FACILITY NAME (If not in:		9b. CITY	r, TOWN	OR LOCATI	ON OF D	EATN		9c. COU	NTY OF DE	ATN			
0 8	3919 WILKEN		BALTIMORE BALT						TIMORE CITY					
입	10s. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
DIRECTOR	MARYLAND		,		TIMO	RE					LIMITS?			
7	10e. STREET AND NUMBER				10	. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?		
6	3919 WILKE					2122	29			II	S.A.			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR								OF NISPAI	NIC ORIGI	N7 (Specify Yes	or No-	14. BACE	- American Indian.
	1 Never Married 2 Married IF YES, GIVE WAR OR DATES							ecify Cubi			Rican, atc.)		Specifi	White, etc.
B	3 X Widowed 4 Divo	rced					- Louis	X						WHITE
COMPLETED		EDENT'S EDU		1	ECEDENT'S	work done	during me	ON ost of worki	ina	164	b. KIND OF BU	SINESS/IN	DUSTRY	
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	- 1	fe. Do NOT u	se retired.)								
P	8TH GRADE			T	RUCK	DRIV	ER			7	CRUCKI	NG CC	MPAN	Z
ő	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOT	HER'S NA	AME (First,	Middle, Maiden	Surname)		
BE C	WILLIAM FR	EDERIC	K KEIL					L	ENA	DENN	ABERG			
	19a. INFORMANT'S NAME (7	/pe/Print)		-1	9b. MAILING	ADDRES	S (Street				nber, City or Tox	rn, State, Zi	ip Code)	
5	WILLIAM KE	IL			3919	WIL	KENS	AVE	NIIE	- BA	LTIMOR	E. M	D 21	229
	208, METHOD OF DISPOSIT	ON		20b. PLACI	E AND DATE	OF DISPO	SITION/N		1100	_				
	20s. METHOD OF DISPOSITION 1 \(\tilde{\mathbb{K}} \) Burial 2 \(\tilde{\mathbb{C}} \) Cremetion 3 \(\tilde{\mathbb{R}} \) Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, cremetory or other place) 1 \(\tilde{\mathbb{L}} \) Donation 5 \(\tilde{\mathbb{C}} \) Other (Specify) \(\tilde{\mathbb{L}} \) DATE 20c. LOCATION — City or Town, State 10/18 BALTIMORE													
	21. SIGNATURE OF PUREITS	L BERVICE US	profit /	///	UN_IA	22.	NAME A	ND ADDRE		ACILITY				-
	HUBBARD FUNERAL HOME, INC.													
	(Lake	11	/	7		_			_		UE - B			MD 21229
	23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only officialise on each line. IMMEDIATE CAUSE (Finel													
	disesse or condition III VAS													
	resulting in death) a. DUE-970 (an AS A CONSEQUENCE OF):													
7	Crother Wast Kulkas													
CERTIFICATION	Sequentisity list conditions, Due to long as a consequence of i													
CAT	if any, leading to immediate cause. Enter UNDERLYING													
Ē	CAUSE (Discess or injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):													
F	reaulting in death) LAS	T	d											
	PART II. Other significa	nt condition	as contributing t	o deeth but no	requiting	In the u	nderlylr	Causa D	given In	n Dart I	24a, WAS AF	ALITOPEY	245	WERE AUTOPSY FINDINGS
EDICAL	PART II. Other significa	int condition	is continuoting t	o deetii oot iio	resolding	III LINE U	indeniyii	ig cause	given ii	raiti.	PERFO		240.	AWAILABLE PRIOR TO COMPLETION OF CAUSE
ă											1 TYES	NO NO		OF DEATH?
Z														1 YES 27 NO
ä	DID TOBACCO U	SE CONT	RIBUTE TO CA					-	CERTAI	IN 🗆				
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	28. PL	ACE OF DEA	OTHE)						
Si	1 TYES 2 NO			☐ ER/Outpatient	3 🗆 DOA			ne 5 X F	Pesidence	a 🗆 Oth	er (Specify)			
H	27. MANNER OF DEATH		28s. DATE O (Month,	F INJURY Day, Year)	28b. TII	WE OF	28c. IN	JURY AT ORK?		28d. DI	ESCRIBE HOW	INJURY O	CCURED	
BY	1 Natural 5 2 Accident	Pending Investigation				M	1 🗆	YES 2	□ NO		-		-	
0	0 D 0-1-14-	Could not be	28e. PLACE building	OF INJURY — At , etc. (Specify)	home, ferm,	etraat, fe	ctory, offi	Ce			CATION (Street		er or Rurel A	oute Number,
ш	4 Nomicide	detarmined											~	
LE	29e. CERTIFIER	TIFYING PHYS	ICIAN: To the best of	of my knowledge,	daath occur	red at the	time, dat	e and plac	a, and du	e to the c	suse(a) and me	nner as at	sted.	
COMPLET	(Check only one) 2 MED	ICAL EXAMINE	ER: On the basis of	axemination and/o	or investigati	lon, In my	opinion,	death occi	ured at th	ne time, da	ta and place, a	nd dua to	the cause(a) and manner ea stated.
8	COL CICHATURE AND TITLE	OF CERTIFIE	1	111				T 00 111	0001000001	14050		Landa	YE GIONED	Marin Day Mari
38	296. SIGNATURE AND TITLE OF CERTIFIES 29d. DATE SIG									I SIGNED	(Month, Day, 1687)			
9	30. NAME AND ADDRESS O	E DEPARTURE	ACCOUNTS OF THE PARTY OF THE PA	HEE OF BEATH	rew on a	a 0-1-01		1	UT	711			10-	76-70
							*****		DATE	DTM/OT	T MT			
	DR. MIQUEL	HERE		3 COMMO		TH A	VENU	1F -	RALI	LIMOR	L, MD			
0	31. DATE FILED (Month, Day,	_	32. REGISTE	RAR'S SIGNATURE										
1	OCT 1 8199	J YE	UN PURINCE	- FRANCE										
														DHMH-16 Rev 1/8



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permit. Pages 1, 2, 3 should use as the burial-transit death, Page 6 may be retained by the hospital or attending physician, the funeral director, page 5 should be detached for 76 notified å examiner must medicai in by filled the cremation, completely other traumatic event, and com prior to 0 the atten injury, shows any signed ! been t. of Dept. certificate to the State this c marked, After I death .00 DIRECTOR: A 28 item THE HOSPITAL O THE FUNERAL DI filed within 72 ho TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 21:52 P YEAR Carol Ann Kemzura 1995 October 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) NOV. 17,1944 B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M ZXXXF Maryland 219-40-0362 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Johns Hopkins Bayview Medical Ctr. Baltimore City N/A DIRECTOR RESIDENCE OF DECEDENT 19c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Dundalk Maryland Baltimore 1 YES 2 XNO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE 21222 2806 Creston Road United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puerio Ricen, etc.)

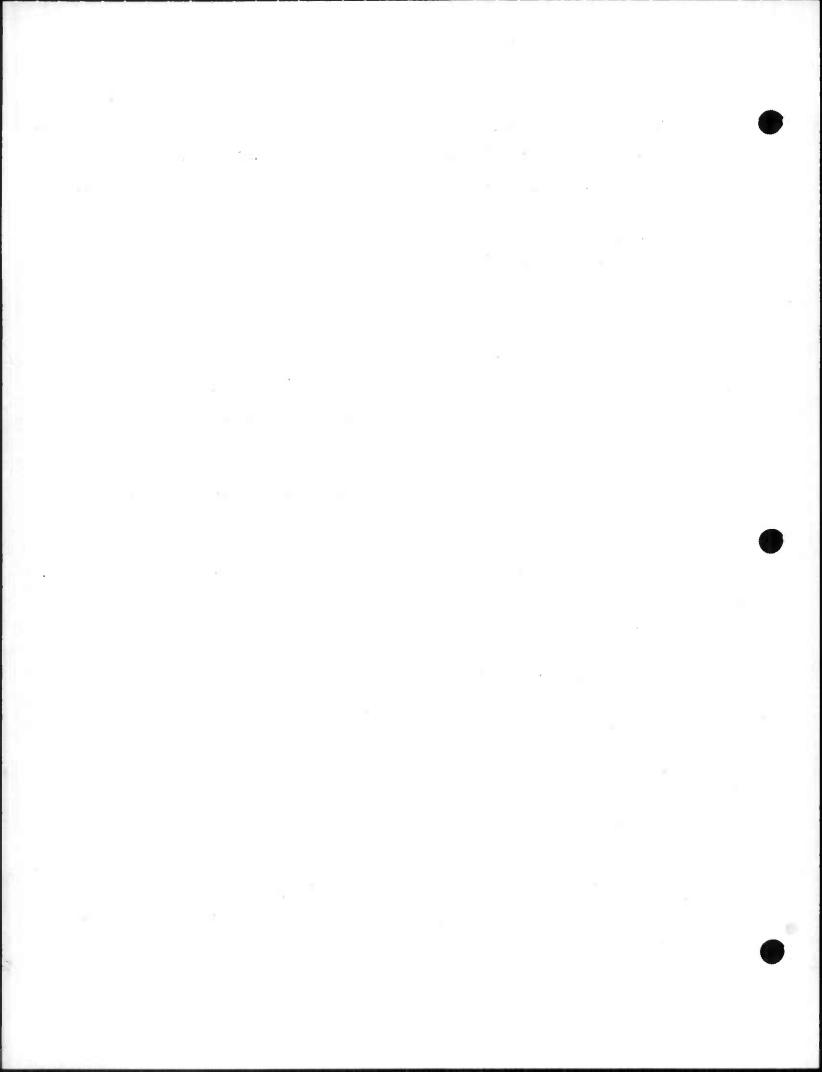
1 YES 2 NO Specify: 14. RACE — American Indian, 1 Never Merried 2 X Merried Specify: BΥ 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondery (0-12) Telemarketer COMPLI Telemarketing 12 Years 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) Ann T. Blockus Aloysius Joseph Matthews 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Creston Road Dundalk, Maryland Frank F. Kemzura 20s. METHOD OF DISPOSITION
1AL Burlel 2 Cremetion 3 Removal from State
4 Donation 6 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Sacred Ht. Of Jesus Cem. 10/19/9\$ Dundalk. Maryland 21. SIGNATURE OF FUNCHAL SERVICE LICENSEE Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23. PART I. Enter the dischase, or complications that caused the desth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or their fellure. List only one cause on each line. Approximets interval Between Onset and Death IMMEDIATE CAUSE (Fine) ulmon disease or condition_ resulting in death) DUE TO (OR AS A CONSEQUENCE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 TO NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO M UNCERTAIN IN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpetient 2 | ER/Outpetient 3 XDOA 28e. DATE OF INJURY (Month, Day, Yeer) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, streat, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 29s. CERTIFIER 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner ee stated. 2 MEDICAL EXAMINER: On the basis of occured at the time, date end place, end due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 114206 29d, DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MI 59 DUNDALKAUB

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH onald 86 nthonu 0 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF EMDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State 56 FER permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3309 WOODEIPPLE ROAD Baltimore DIRECTOR JOODLAWN RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimure Maryland 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 21239 1236 use as the burial-transit 10 1514 when the control of the cetained by the hospital or attending physician. If the thinks director, page 5 should be detached for use as the burlat-tran 1. MABITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 PRO IF YES, GIYE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life, Do NOT use retired.) 15. DECEDENT'S EDUCATION 16h KIND OF BUSINESS/INDUSTRY (Sn) SOICHESTER Minifacturi College (1-4 or 5+) BENUISOY 1810VS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First To JOSEPH BE llian HOWARD notified a 19a INFORMANT'S NAME (Type/Print) 21207 2 1000 Ribble Road Marytons must be METHOD OF DISPOSITION
Burlal 2 Cremation 3 Removal from State 10 PATE G ZOC. LOCATION - City or Ton 20b. PLACE AND DATE OF DISPOSITION IN Donation 8 - Other (Specify) STENSTON 21. SIGNATURE OF FUMERAL SERVICE LICENS the medical examiner 5340 HATMAN-Homis Boltimore, Nel 21211 filled in by the s, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23, PART I. Enter the diseas Approximate sheck, or heart allure. List only one ceuse on each line. Interval Betwe b IMMEDIATE CAUSE (Final Onset and Death cremation. disease or condition ANCREAMIN been signed by the attending physician and completely int. of Health and Mental Hygiene prior to burial, crematili event, DUE TO (OR AS A CONSEQUENCE OF): traumatic Use CERTIFICATION Sequentially list conditions, If any, laeding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): 8 certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE that INFELTION shows any 1 TYES 2 TH NO DF DEATH? requires 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES M NO UNCERTAIN 🗀 this certificate has be with the State Dept. WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL 1 W YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 N Residence 8 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked 1 Natural 2 NO BY 1 YES After death 2 Accident Investigation DR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 28 ls a 3 Suicide LOCATION (Street and Number or Fural Route Number, City or Town, State) 6 Could not be DIRECTOR: / COMPLETED 4 🔲 Homleide If Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(e) end menner se stated TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If IN 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (North, Day, Year) up most Phacin 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1411



BALTIMORE, MARYLAND 21215-0020

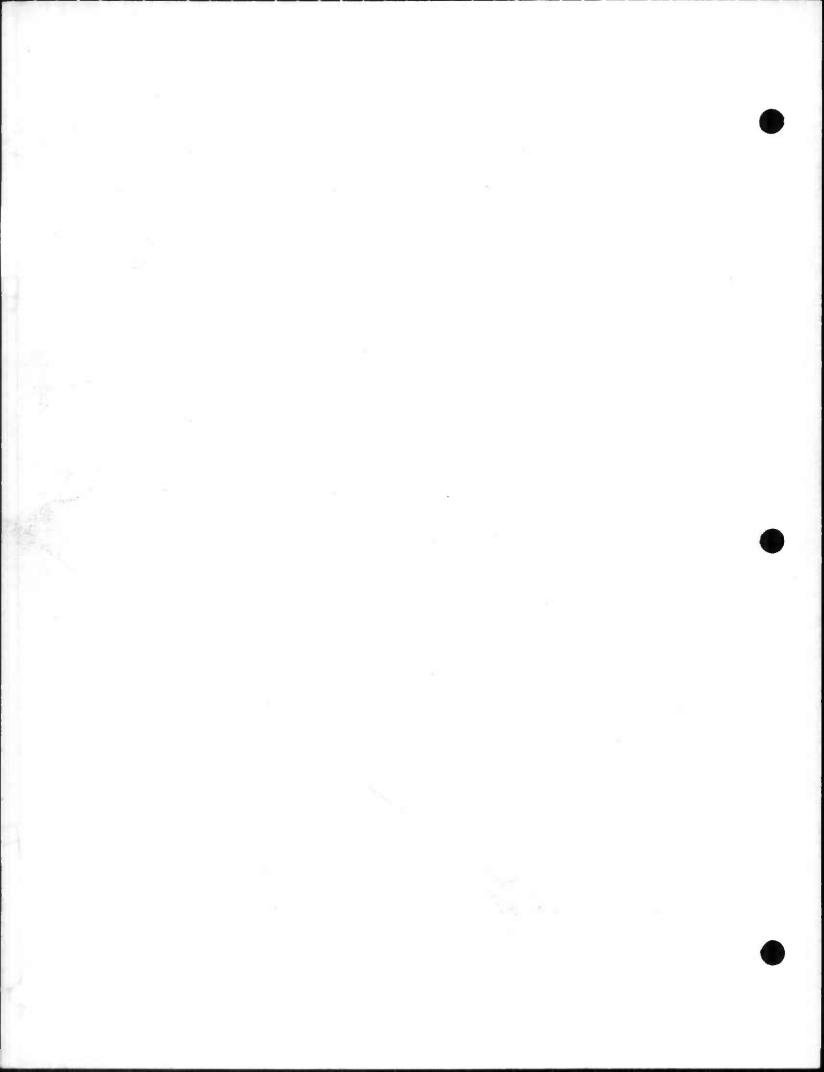
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN
	<u>Michael</u> Casper	LE:	ILICH			October 1	6,1995 YEAR	7:40 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTI	IPLACE (State or Foreign
	217-05-1827	1 🖾 M 2 🗆 F 84	YRS.	NTHS DAYS	HOURS MIN.	May 1, 191	1 Ma	ryland
_	9s. FACILITY NAME (If not institution, give st		91	. CITY, TOWN C	R LOCATION OF DE	ATN	9c. COUNTY OF D	
DIRECTOR	Franklin Square	Hospital		Baltim	ore		Baltimo	re
ទួ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY T	OWN OR LOCAT	101			
E I		timore		timore	ION			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	JIMOI C	Dai		ZIP CODE		40. 0	1 YES 2XX NO
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	1 Never Married 2 Married	FORCES? 1 X YES	2 NO		cify Cuben, Mexica	n, Puerto Ricen, etc.)	Biaci	t, Whits, etc.
BY	3 📉 Widowed 4 🗌 Divorced			1 723	ZA NO Specin	γ.	Speci	White
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	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT use re	tired.)	at or working			100
MP	12 Years		Carpente	r		Self Emp	ployed	
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden S	Surname)	
BE	John Leilich				Cecel:	ia Jager		
2	198. INFORMANT'S NAME (Type/Print) Mrs. Janice Parks					Ploute Number, City or Town		
	201 METNOD OF DISPOSITION					ad Balto. N		
	1 Burisi 2 Cremetion 3 Ramo	ovel from State 20b	PLACE AND DATE OF D	ISPOSITION (Ne	me of	DATE 20c. LOC n10/19/95 I	CATION — City or To	wn, Stats
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIQ	ENSEE	Ty HILLS	Tellior Ta	D ADDRESS OF FA	110/19/92	salto. MI)
	· Znanti	Dinnel	6			The Dipp	el Funer	al Home
	manum	4. Dupper	M	7110 I	Belair Ro	oad Baltimo	ore, Mary	land 21206
ĺ	23. PART I. Enter the diseases, or c shock, or hasrt fallure. I	omplications that caused	the desth. Do not sch ilne.	enter tha mo	de of dying, auci	h ss cerdisc or respir	atory arrest,	Approximats interval Between
- 1	IMMEDIATE CAUSE (Final			KI	18 1000	rator)	Onset and Death
	disease or condition resulting in desth)			20	MAP	ker on		
	DUE TO (OR AS A CONSEDUENCE OF):							
ERTIFICATION	Sequentially list conditions,	DUE TO (DR AS A	CONSEDUENCE OF):					
Ę	if sny, leading to immediate csuse. Enter UNDERLYING	55C 10 (511 X5 X	CONSEDUENCE OF).					
띮	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEDUENCE DF):					
F	resulting in death) LAST	t						100
ပ	PART II Other cignificant condition							
ă I	PART ii. Other aignificant conditions	i contributing to death be	ut not resulting in t	ne underlying	cause given in	Part i. 24a. WAS AN A PERFORE		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă						1 _ YES 2	DINO.	OF DEATH?
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CIAN: MEDIC	DID TOBACCO USE CONTR				UNCERTAIN	1 D		
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	THER:				
PHYS	1 YES 2 NO	1 Inpetient 2 ER/Outp	atient 3 DOA 4 (6 Other (Specify)		
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WO	PK?	28d. DESCRIBE NOW IN	JURY OCCURED	
B	Accident Investigation	28e. PLACE DF INJURY	- At home, farm, stree			28f. LOCATION (Street or	ad Alumbas as Guard E	huts Mushes
	3 Suicids 6 Could not be determined	building, etc. (Spec	Hy)	.,,		City or Town, State)	or normal or normal or	oute Number,
COMPLET	29a. CERTIFIER CERTIFYING PHYSIC	NAME TO the best of an incident		late de caso	200 T 677			
₹		ZAN: To the best of my knowledge. On the basis of examination						100 CO CO CO CO CO CO CO CO CO CO CO CO CO
- 14	29b. SIGNATURE AND TIME OF CERTIFIER			Tily opinion, or				124
W	PIMIL	1111	7		199. LICENSE NUN	IBER	29d. DATE SIDNED	(Morith, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED OF DE	ATN (ITEM 27) (Kinsa Dele	(1)	10/16	2 /	100	1-2
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	31. DATE FILED (Mopph, Deprymer)	Manufamilian	adhe			· · · · · · · · · · · · · · · · · · ·		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the 1	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

821 N. Eutaw St. Suite 308

32 REGISTRAR'S SIGNATURE

Shoaib Hashmi,, M.D.

31. DATE FILED (Month, Day, Year, DC), 1 0 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH October 15,1995 **THOMAS** BARRON LAUER 8:30 A. M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign MONTHS DAYS NOURS 1 X M 2 - F 215-01-9396 78 July 18, 1917 Maryland Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital N/A Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore City 1 X YES 2 NO 10a STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3202 Cedarhurst Rd. 21214 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 X Merried IF YES, GIVE WAR OR DATES Specify: White BY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life, Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPL 1 yr Engineer Martin Marietta Co. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) John Florine Pines Lauer BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Miss Susan F. Lauer Same as #10 20a. METNOD OF DISPOSITION
1 X Buriel 2 Cremetton 3 Removat from State
4 Donetton 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Parkwood 10/19/95 Baltimore.MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. 22. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 Haul X. Hartrock Leonard J. Ruck, Inc. 5305 Harford Rd. Ьz. 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between ahock, or heart failure. List Dnly one cause Dn each line. **Onset and Death IMMEDIATE CAUSE (Final** disease or condition Belaleval 1 removes reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Dementie CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY MEDICAL PERFORMED: AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) HOSPITAL: 1 | YES 2 | 10 estient 2 - ER/Outpetient 3 - DOA 27 MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide 29e. CERTIFIER
(Check only one)

MEDICAL EXAMINED: On the best of available of available of a variab 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE (Claure 10117185 730641

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 10:30a.m. Oct.15,1995 Max P. Laffler 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) May 11,1924 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 K M 2 | F 216-18-4235 71 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 108 Werner Rd. Marley Anne Arundel RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Marley Maryland Anne Arundel 1 - YES 2 NO UNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 108 Werner Rd. 21226 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yae or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 K Never Married 2 Married Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE, MARYLAND 21 COMPLE Elementary/Secondary (0-12) College (1-4 or 5+) 益 hospital 12 Loftman Maryland Drydock funeral director, page 5 should be netached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) hours after death. Page 6 may be retained by the Ħ Laffler BE Max Catherine Unknown notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Stedding 108 Werner Rd. pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 Buriel 2 Cremetion 3 Removal from State Cedar Hill Oly Cross ☐ Donation 5 ☐ Other (Specify) Cemetery Oct. 19,1995 Baltimore, Md. 21225 examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCUITY Funeral Home 3204 Mountain Rd. Pasadena, Maryland 21122 nou signed by the attending physician and completely filled in by the Health and Mental Hyglene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heert fellure. List only one ceuse on each line Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition DUE TO (OR AS A CONSEQUENCE OF) event. resulting in death) BOX 6876 diovalcular disease Hypertentive
JOHE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING eter HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) P.O. that initieted events resulting in death) LAST 6 Injury. DIVISION OF VITAL RECORDS, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 - YES 2 X NO nt. of Healt 1 YES 2 NO Dept. c. 23 sh DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate has his with the State Darked, or Item Item **EXAMINER?** HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. INJURY AT WORK? 27. MANNER OF DEATH 1 Natural 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 5 Pending Investigation DIRECTOR: After the hours after death witten 28 is mark 1 YES 2 NO BY Accident 28a. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide determined 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date and place, end due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(e) end menner ee stated. 29b. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE D 10 16/95 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SEENIVASAN, MD 606 Hammonds lave BALTO MO, Actor Hacken Partal

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO

2. DATE OF DEATH MONTH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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VISION OF VITAL RECORDS, P.O. BOX 68760	
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213-31-69 7. DATE OF BIRTH (Month, Day, Year) Dec 10, 1940 6. AGE (In yrs. last birthday 694 YRS. Pages 1, 2, 3 should EACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH vorthwes DIRECTOR Spita RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL STREET AND NUMBER 101. ZIP CODE 2505 244 raire We retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. MAMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)
 T YES 2 NO Specify: 1 Never Married 2 Merried BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION gq (1-4 or 5 +) ashier A once. DEFATHER'S NAME (First, Middle 18 MOTHER'S NAME (First, Middle 76 as BE aci notified THEORMANT'S NAME (Typ 19b. MAILINO ADORESS (St 2 0 hours after death. Page 6 may be Pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must b BATE . 2 Cremetion 3 🗆 Donation 5 - Other (Specify) 22. NAME AND ADDRESS OF FACILITY the medical examiner OF FUNERAL SERVICE LICENSES 4larch f 43 a ba attending physician and completely filled in by the intal Hygiene prior to bunal, cremation, or removal. 00 23. PART I. Enter the opening, or complications that caused the abook. or heart failure. List only one cause on each line. e, or complications that caused the deeth. Do not enter the mode of dying, auch ea cardiec or reepiratory arrest, IMMEDIATE CAUSE (Final disease or condition END STAGE RENAL FAILURE reaulting in death) traumatic event, DUE TO (OR AS A CONSEQU executed PNEUMONIA CERTIFICATION Sequentially list conditions, if any, leading to immediate DIABETES cause. Enter UNDERLYING CAUSE (Disease or Injury or other sen signed by the attending phy of Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other algorificent conditions contributing to test but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERTENSION PERFORMED? ESSENTIAL shows any 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \bowtie Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) item HOSPITAL: State certificate 1 TYES 2 NO OTHER: Inpetient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT TIME OF 26d. DESCRIBE HOW INJURY OCCURED : After this cr 1 Netural м 1 YES BY Accident ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) TO THE HOSPITAL OR ATTENDIN TO THE FUNERAL DIRECTOR: At be filed within 72 hours after de IMPORTANT: If Item 28 Is r 60 ETED. 3 Suicide 8 Could not be 4 Homicide determined COMPL (Check only one) ation, in my opinion, death occured at the time, date and place, end due to the cause(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER BE 2 NBRTH

JAMES

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3. TIME OF DEATH YEAR 95 B. BIRTHPLACE (State or For 9c. COUNTY OF DEATH 20 0 10d. INSIDE CITY 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 14. RACE — American Indian, Black, White, etc. Specify: A C 16b. KIND OF BUSINESS/INDUSTRY Supply eac ma 130 2124 to 20c. LOCATION - CHY or To Woodlawn **Approximate** Interval Between **Onset and Death** 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year)

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withmr 24 hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attend	hours after death with the State Dept. of Health and Merital Hyglene prior to burial. Cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYS	=	be filed within 72 hours after death with	IMPORTANT: If item 28 is marked

	FOR						31356
	1 - STATE REGISTRAR	STATE OF MARYLAND / CE	DEPARTMENT RTIFICATE	OF HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)	MARX			2. DATE OF DEATH DO	1995	AR 4:30AM, M
		SEX 6. AGE (In yrs. lest	YRS. MONTHS	1 YEAR IF UNDER 24 HRS. DAYB HOURS MIN. TOWN OR LOCATION OF E	7. DATE OF BIRTH (Month, Day, Year)		SIRTHPLACE (State or Foreign Country) RKAOSAS
стов	HART HERITALS	nursing Hos	N 5	REST	CAIN	HAR	REORO
JEC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN C	PR LOCATION			10d. INSIDE CITY
IL DIRE	100. STREET AND NUMBER	_G X	COR	OOVA 10f. ZIP CODE		10g. CITIZEN	1 YES 2 □ NO OF WHAT COUNTRY?
FUNERA	8830 CEDAR	17:14 LIRC	15	38018		U	S.A.
BY FUR	11. MARITAL STATUS 1	E. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES	0	WAS DECENDENT OF HISPA If yee, specify Cuben, Maxic I YES 27 NO Spec	en, Puerto Ricen, etc.)	s or No— 14.	RACE — American Indian, Black, White, etc.
ED E	15. DECEDENT'S EDUCATI		CEDENT'S USUAL O		16b. KIND OF BU	SINESS/INDUST	WHI S
H	(Specify only highest grade con Elementary/Secondary (0-12)		be kind of work done to NOT use retired.)	during most of working	DWN	HOME	
COMPL	17. FATHER'S NAME (First, Middle, Last)	00/2			AME (First, Middle, Maiden		
) BE	190. INFORMANT'S NAME (Type/Print)		. MAILING ADDRESS	(Street and Number or Rura	Route Number, City or Tox	n, Stele, Zip Coo	2018
2	KANDAU S. MAR	× 5	OF DAY	10 ORIV	BELAI	R. MA	RYLAND
	20e, METHOD OF DISPOSITION Burlel 2 Cremation 3 Remova 4 Donation 8 Other (Specify)	I trom State gemetery, crer	metory or other piece	SITION (Name of	DATE 200. LO	CATION — CHY	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN		4.1	NAME AND ADDRESS OF F	ACILITY LI OP	-027	AIR P.A.
	1 Your to	Dam /	3	PSW FURE	OB: NI	FASS	-11 11 mais
	23. PART I. Enter the diseases, or con ahock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	t only one cause on each line.			ch es cerdiac or raep	Iratory erreet	Approximate Interval Between Onset and Death
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (DISEASE						
RTIF	that initiated events reaulting in death) LAST	DUE TO (OR AS A CONSEC	PUENCE OF):				
MEDICAL CE	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED?						24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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AN	DID TOBACCO USE CONTRIE		TH YES E OF DEATH (Check		IN LI		
SICI	EXAMINER?	IOSPITAL:	OTHE		6 Other (Specify)	ASSiS	ED CARE
PHYSICIAN:	27. MANNER OF DEATH 15. Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUR	ED
2 Accident a lovestigation investigation as a lovestigation as a loves						Rurel Route Number,	
COMPLET	29a. CERTIFIER (Check only	IN: To the best of my knowledge, de					suse(e) and manner se stated.
BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER	- M		29c. LICENSE N			GNED (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEATH (ITEL	M 27) (Type, Print)	1421	001	1.00	11,1995
	OR. DAVID W. M	32. REGISTRAR'S SIGNATURE	SLAURE	L Bush K	OAO		
	OCT 1 8 1995 Ja	Si Studior Revall					

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DR.	SHE	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	2	E

							-	35	31331
	1 - STATE REGISTRAR	TATE OF MARYLA		TMENT DF		MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	111				2. DATE OF DEATH	W.	YEAR 3.	TIME OF OEATH
	Johnnie McGour	in, III			_	10	12	75	8:37 Am
	11 217-		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHPL Country)	ACE (State or Foreign
	218-46-21(0)	QM2□F	46 YRS.	MONTHS DATS	HOUNS MIN.	11/21/1	948	Balt	O., MD
	9a. FACILITY NAME (If not Institution, give street a	and number)		96. CITY, TOWN	OR LOCATION OF DE	EATH	9c. COUN	TY OF DEA	тн
8	VA Hospital			Balt	more			N/A	
ן ק	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		sne Cit	Y. TOWN OR LOC	ATION			1	Od. INSIDE CITY
DIRECTOR		/A		altimo					LIMITS? YES 2 NO
	10e. STREET AND NUMBER	/ A			Of, ZIP CODE		10a. CITIZ		AT COUNTRY?
FUNERAL	2637 Garrett Av	enue			21218		109.0111	US	
빌		WAS DECEDENT EVER IN	US ARMED	13 WAS D		NIC ORIGIN? (Specify Yes	or No-		- American Indian,
	1 Name Married 2 Married	FORCES? 17 YES	2 NO	If yes,		en, Puerto Rican, etc.)		Black, \ Specify:	White, atc.
ΒY	3 Widowed 4 Divorced 6	/14/67 6/	6/70		as ax 100 specifi	y		арвопу.	Black
9	15. DECEDENT'S EDUCATIO		16a. DECEDENT'S	USUAL OCCUPA work done during		16b. KIND OF BU	SINESS/IND	USTRY	
ᄪ		ollege (1-4 or 5+)	life. Do NOT u	se retired.)		Bus	ines	s Ma	chines
COMPLETED	12th	4	Tech	niciar	1				
į	17. FATHER'S NAME (First, Middle, Lest)					AME (First, Middle, Malden	Surname)		
ш	Johnnie McGowan	, II			Bessi	e Martin			
10 B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			
F	Bessie McGowan		2637	Garre	tt Aven	ue, Balt	imore	e,MD	21218
	20a. METHOD OF DISPOSITION 1 Burial 2X Cremation 3 Removal		PLACE AND DATE			1	CATION - 0	City or Town	n, Stata
	4 Donation 6 Other (Specify)	Me	etary, crematory or cettro Cr				tons	vill:	e, MD
	21. SIGNATULE FUNERAL SERVICE LICENS	9) (()	A		AND ADORESS OF FA	ETT & SO	u EIII	MEDA	I. HOME
	> N/3 17/ C), IUR	u			Y HEIGHT			21207
	23. PART Later the diseases or comprison, or heart alure. List	plications that	the deeth. Do						Approximata
	IMMEDIATE CAUSE (Final	only one cause in e	ach line.						Onset and Death
	disease or condition	Seosis							1 day
	reaulting in death) a	DUE TO (OR AS A	CONSEQUENCE	OF):				_	1 000
z		Peritoni.	+is						1 week
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE	OF):					<u></u>
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	Cirrhosis							5 months
E	that initiated events		CONSEQUENCE						
E	reaulting in death) LAST	Hepatitis	C int	ection					years
O	PART II. Other algolficent conditions co	ontributing to deeth b	out not resulting	In the underly	Ing ceuse given in	Part I. 24a. WAS AM		24b. V	VERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Coagulopathy		_			PERFO		0	WAILABLE PRIOR TO COMPLETION OF CAUSE
EDI	- Doug-wope,					1 TYES	NO		OF DEATH?
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE C	E DEATH V	ES TI NO	UNCERTAI	ND		_	☐ YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE						
CI		OSPITAL:	neticet 1 DOA	OTHER:	ama & C Basidanaa	A C Other (Specific)			111
175	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. Til		ome 5 Residence	28d, DESCRIBE HOW	INJURY OCC	CURED	
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	/ — At home, ferm,			28f. LOCATION (Street		or Rural Ro	ute Number,
9	4 Homicide B Could not be determined	building, etc. (Spec	cify)			City or Town, State)		
COMPLET	29a. CERTIFIER . M CERTIFYING PHYSICIAN	I. To the heat of our boars	uladaa daath ar	mad at the time of	ete and place and di-	is to the emissist and an	nner es el-t	ad	
MP	(Check only one) 2 MEDICAL EXAMINER: 0	N: To the best of my know on the basis of examination							and manner as stated.
8				,, opinio					
BE	280. RIGHATURE AND TITLE OF CERTIFIER	- ani	2		29c. LICENSE NU P0776		29G. DAT	SIGNED (Month, Day, Year)
2	THE HAME AND ADDRESS OF PERSON WHO CO	ON ETED CAUSE OF DE	ATH (ITEM 27) /To	e Print)	10116	~	1	0/12	143

TESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

I + SiOS MD University of Mary land

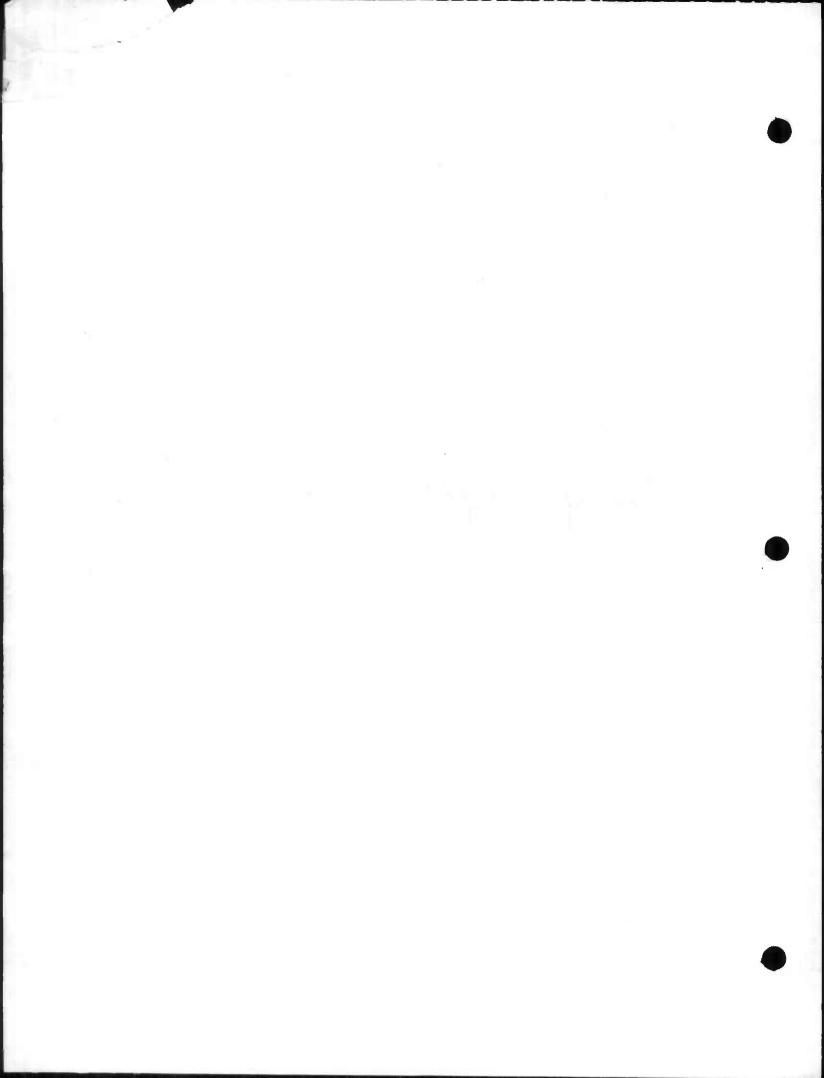
1995 Julia Disuble Robert

When the complete of the OHMH-16 Rev 1/89

Dept. of Medicine 22 S. Greene St. Bultimore, MD 1595

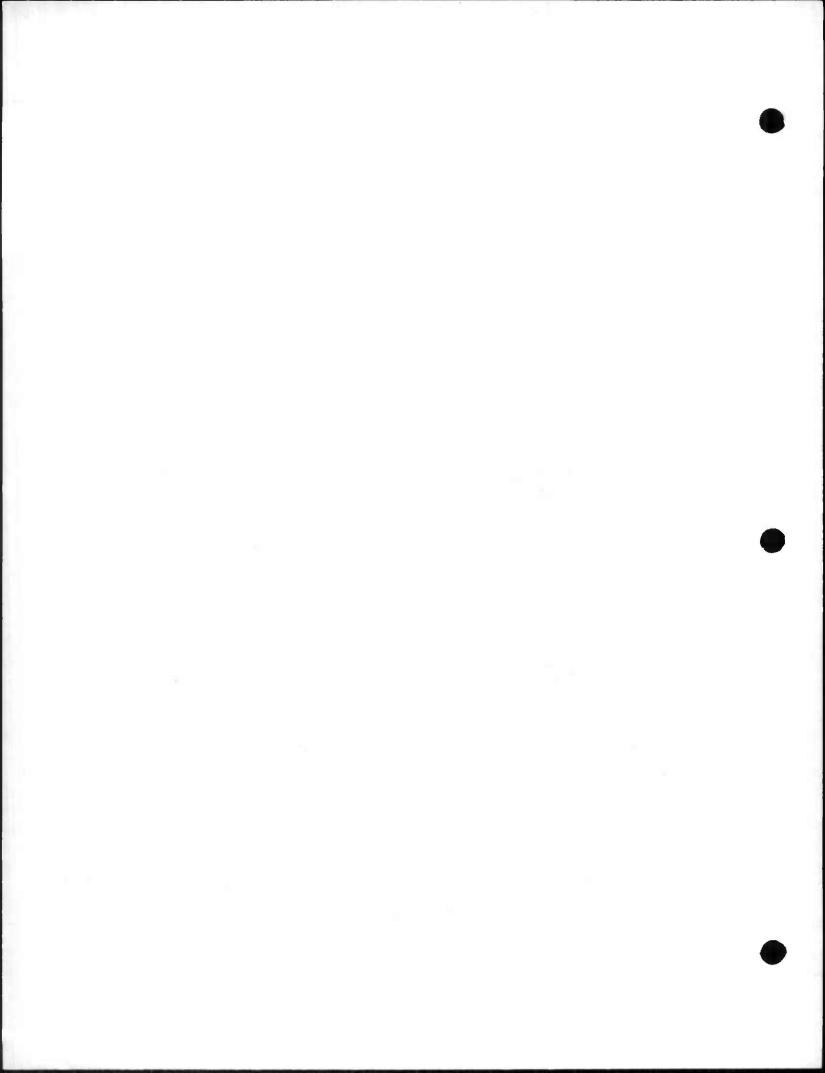


Helen Nitsias
31. BATE FILED (MODILI, DON, MODIL)
OCT 1 81995



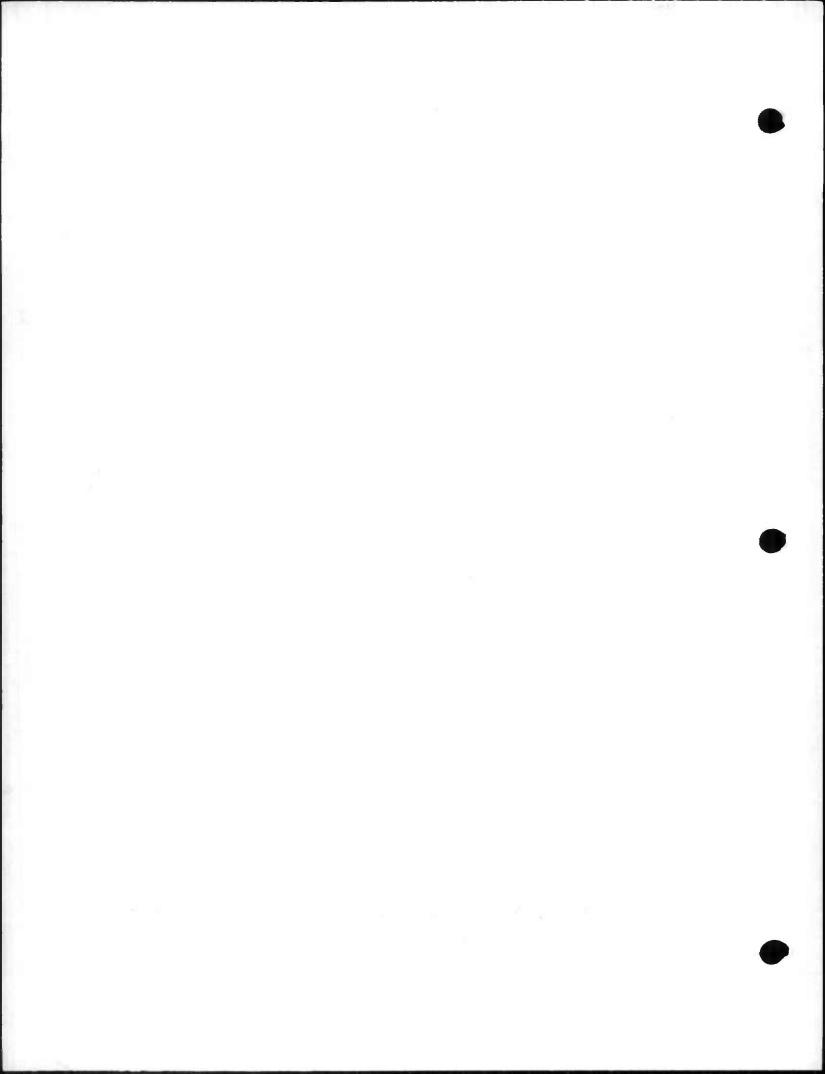
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, LA	aline E. Myers				2. DATE OF DEATH DON'TH D.	AY YEAR	
	4. SOCIAL SECURITY NUMBER 500-30-9485	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Oct 16.1 7. DATE OF BIRTH (Morrity Description) Sept 29,	1.007 Co	3:05 P M HTHPLACE (State or Foreign unity) Louis, Mo
SB	90. FACILITY NAME (If not institution, g 8558 Biscayne Co				Marlboro	EATH	9c. COUNTY O	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COL		10c. CIT)	, TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland Pr:	ince George's	Ur	pper Mar				1 YES Z NO
FUNERAL	8558 Biscayne	Court		101.	20772		4.0	States
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 200	13. WAS DEC	city Cuben, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No — 14. R	ACE — American Indian, lack, White, etc.
	15. DECEDENT'S (Specify only highest g	EDUCATION (rade completed)	(Give kind of w	USUAL OCCUPATIO	N st of working	16b. KIND OF BU	SINESS/INDUSTR	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	gal / Ow		Myers	Tariff	Bureau
BE CON	17. FATHER'S NAME (First, Middle, Last) Simon Paul Eval					ME (First, Middle, Meiden Lorence Mc		45
TO B	19a. INFORMANT'S NAME (Type/Print) David Kelly		196. MAILING 8558 1	ADDRESS (Street of	nd Number or Rural I	Route Number, City or Tow Upper Mar]	n. State, Zip Code)	d 20772
	20a. METHOD OF DISPOSITION SCHOOL 2 Cremation 3 5	Removal from State Car	place and date of the control of the	F DISPOSITION (Na	me of Oct 19	, 1995 20c. LO	CATION — City or	Town, State
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	and the same of th	OLC THIC		-	CIUTY CE Fune	entwood,	Maryland ne,Inc 6633
Ц	· Joyal	Set Sa		Old Al	exandria	Ferry Roa	ad, Clin	nton, Md 20735
	23. PART Enter the diseases ahock, or heart fellu	ire. List only one ceuse on e	ach line.				iratory arrest,	Approximate Interval Between Onset and Daath
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):							
NOI	Sequentially list conditions, If any, leading to immediate b Due to (or as a consequence of):							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):				
ERTI	resulting in death) LAST	d						İ
A.	PART II. Other algolficant condi	tions ontributing to death b	ut not resulting l	n the underlying	cause given in	Part I. 24a. WAS AN PERFOR	AUTOPSY 2	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC						1 TYES 2	NO	OF DEATH?
	DID TOBACCO USE COI		F DEATH YE		UNCERTAIN	V 🗆		
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	5 KRasidence	6 Other (Specify)		
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	JRY WOI	JRY AT RK? ES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCUREO	
	3 Suicide 6 Could not determined		— At home, ferm, e	treet, factory, office		281. LOCATION (Street of City or Town, State)	and Number or Run	al Route Number,
COMPLETED		HYSICIAN: To the best of my know						e(e) and manner ee stated.
TO BE	296. SIGNATURA AND TITLE OF CENTS				29c. LICENSE NUN	7431	29d. DATE SIGN	EQ (Month, Gay, Year)
	Frank M Ryan, I	WHO COMPLETED CAUSE OF DE MD 6188 OXON H			xon Hill	Md 20745-	-3113	
	31. DATE FILED (Month, Day, Year) OCT 1 8 1995	32. REGISTRAR'S SIGN						
		V						DHMH-16 Rev 1/89



FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE (OF DEATH	F	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH
		Edith	L. McCaule	17			MONTH	100E	YEAR	The second secon
11.0		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	OCT 6	BIRTH	a Ric	THPLACE (State or Foreign
		571-01-0565	1 □ M 2/5 F	85 YRS.	MONTHS DA	YS HOURS MIN.	TII V	3, 191	0 Mai	ryland
pinous		9s. FACILITY NAME (If not institution, give s	Δ		Oh CITY TO	WN OR LOCATION OF D				
S SA	œ				90. CITT, 10	WHO HE LOCATION OF DE	EAIH		c. COUNTY OF	e George's
N ²	DIRECTOR	Magnolia Gardens I	Nursing Home		Lan	nam			PLINCE	: George's
es 1	E C	10e. STATE 10b. COUNTY		10c, CI1	TY, TOWN OR L	OCATION				10d. INSIDE CITY
Pages	8	Maryland Prim	ago Coommala							LIMITS?
permit.		100, STREET AND NUMBER	nce George's		oer Mai	LIDOTO 101, ZIP CODE		1	0.000	1 YES 2 NO
	RA	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	•			IUI. ZIP CODE		10	g. CITIZEN OF	F WNAT COUNTRY?
020 physician. burial-transit	FUNERAL	3000 Eton Dri				20772		U		States
21215-0020 al or attending physician. for use as the burial-fran	3	1 Never Married 2 Merried	12. WAS DECEDENT EVER I FORCES? 1 YES	2 NO		DECENDENT OF HISPAI s, specify Cuben, Mexico			No- 14. RA	NCE — American Indian, ack, White, etc.
9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES A	1 🗆	YES 2 NO Specif	y.			ec/ly:
15-0 tending as the	ED	15. DECEDENT'S EDU	CATION	Ma DECEDENTIO	1101111 00011		1			nite
		(Specify only highest grade	completed)	16e. DECEDENT'S (Give kind of Me. Do NOT u	work done durin	g most of working	186, KJ	OF BUSINE	SS/INDUSTRY	
o ital o	1 1	Elementary/Secondary (0-12)	College (1-4 or 5+)							
AND the hospital detached for once.	COMPLET	12	2	House	wife			ome		
rllA be det	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Midd	le, Malden Sum	ieme)	
RYL M be	H	Richard Stalli	nas				Mae B			
ALTIMORE, MARYLAND death. Page 6 may be retained by the hospit huneral director, page 5 should be detached examiner must be notified at once.	6	19e. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (St	reet and Number or Rural	Route Number,	City or Town, St	ete, Zip Code)	
y be re sage 5	-	Nancy L. Miller		8808	Old F	Branch Ave	. Clin	ton. M	d 2073	15
RE, may be or. page		20e. METHOD OF DISPOSITION 1 X Burlel 2 Crametion 3 Rem	ovel from State	. PLACE AND DATE	OF DISPOSITIO	N/Name of Oct 1:	3 1995	20c. LOCATI	ION — City or	Town, State
ALTIMOR leath. Page 6 ma tuneral director. p		4 Donation 5 Other (Specify)	Cen	netery, crematory or o	Church	Cemetery	1	Fores	tville	, Maryland
ALTIN death. Pag e tuneral di u. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1	22. NAM	E AND ADDRESS OF FA	ciuryLee	Funer	al Hor	e, Maryland Ne, Inc 6633
ALL funer funer xam		DO 04-12. 6	m	//	Old	Alexandria	a Ferr	y Road	, Clin	ton, Md 2073
	_	- Jan Yoll Z	Marso	vao						
5 E 5 D		23. PART I. Enter the diseases, or o shock, or heart failure.	complications that cause List only one cause on a	d tha daath. Do i iech line.	not entar the	mode of dying, auc	h aa cardiac	or respirato	ery arrest,	Approximate interval Batween
		IMMEDIATE CAUSE (Final								Onset and Death
d vithin 24 ompletely fill I, cremation, the		disease or condition resulting in death)	. Acnira	tion Dn	oumon i					Sudden
50 mple mple crei			DUE TO OR AS	tion Pn	P:	d				
	z		. Senile	Dement	ia					Years
× 5 5 5	RTIFICATION	Sequantially list conditions, if any, leading to immediate	OUE TO (OR AS A	A CONSEQUENCE O	F):					/
tra prior tra	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	C							/
o ph g ph iene		that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):					
P. Ce andin Hyg	ERI	resulting in daeth) LAST	d.							
the deat y the atta of Mental	O									
A par the No.	DICAL	PART II. Other algnificant condition	a contributing to death b	out not resulting	in the undar	lying cause given in	Part I. 24	PERFORMED		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
0 5 8 5	8						1	YES 2 M	NO	COMPLETION OF CAUSE OF DEATH?
RECC requires been signs of Healt	ME	r								1 YES 2 NO
. 3 4 5 00		DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH Y	ES NO	UNCERTAIL	νП			
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF OEA						
SICIAN: The certificate h the State (1, or item	Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outs	patient 3 DOA	OTHER:	Home 5 - Residence	8 - Other (St	annife I		
ATENDING PHYSICIAN: ECTOR: After this certifical s after death with the St.	Ŧ	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIM		INJURY AT		BE HOW INJUI	RY OCCURED	
NG PHYS fler this auth with		1 Natural 5 Pending	(Month, Day, Year)		JURY	WORK?	2001 0200111	DE 11011 111001	TI COCONEC	
Affer death	B	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF INJURY	/ — Al home Jerm			ORL LOCATIO	M (Orandand)		10 - 11 -
TTENDIN AT AT AT AT AT AT AT AT AT AT AT AT AT		4 Homicide 6 Could not be	building, etc. (Spec	cify)	otions, factory,	omes	City or To	wn, Stete)	rumoer or Hura	I Route Number,
	H.	-								
	COMPL	29e. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurr	ed at the Ilme,	date end place, end due	to the cause(e) end menner	ee stated.	
HOSPITAL FUNERAL WITHIN 72 TANT: IT	O	One) 2 MEDICAL EXAMINE	R: On the basis of examination	n end/or investigation	on, in my opinic	on, death occured at the	time, date and	place, and du	e to the ceuse	r(e) end menner ee stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: It		290. SIGNATURE AND THE OF CENTERE				29c. LICENSE NUI	IBER	294	d. DATE SIGNI	ED (Month, Day, Year)
TO THE HOSPIT TO THE FUNER De filed within 7	8	W/2 h / . C. h)			1277	240		10/1	2/45
FFDE	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	, Print)	1000	0	1		1100
		Peter N Schille	COMPLETED CAUSE OF DE	Croenin	w Gr	. Dr. Gre	enfelt	nd ;	2720	>
1		31. DATE FILEO (Month, Day Year)	32 REGISTRAR'S SIGN	ATURE	1				- 1	
		OCT 1 8 1995	32 REGISTRAR'S SIGN	fall						
_ L				40.4	<u> </u>					



3. TIME OF DEATH

10d. INSIDE CITY

10g. CITIZEN OF WHAT COUNTRY?

USa

Black

14. RACE — American Indian, Black, White, atc.

1 YES 2 NO

REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

AMBACHON

1 -

AVER C IF UNDER 1 YEAR 220052830 IF UNDER 24 HRS. 1 900 2 DF Pages 1, 2, 3 should DIFECTOR 10b. COUNTY 10c. CITY, TOWN OR LOCATION Saltimore permit. FUNERAL 100. STREET AND NUMBER 101. ZIP COOF for use as the burial-transit 21216 venue Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, atc.)
 T YES 2 (A NO Specify: 11. MARITAL STATUS 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION eclly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life, Do NOT use retired.) Person Delivery detached 17. FATHER'S NAME (First, Middle, Last) me lijah 8 notified at manie BE funeral director, page 5 should 0 Maderia pe 20a METHOD OF DISPOSITION

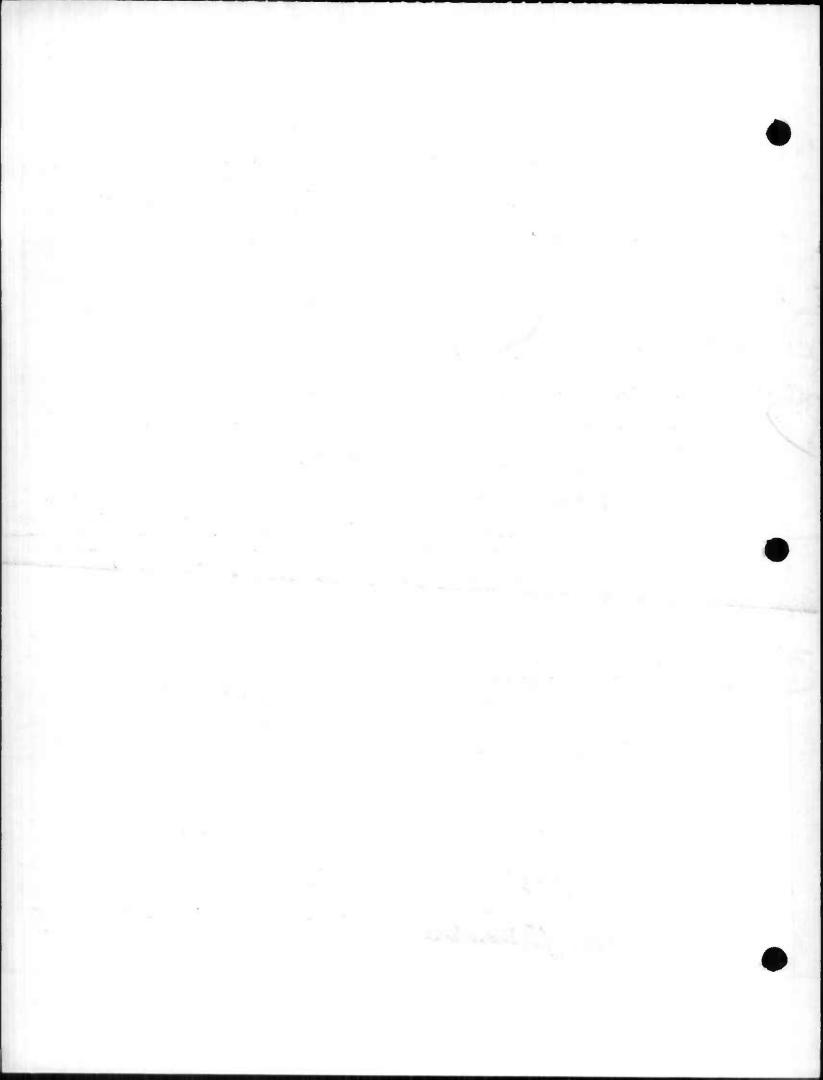
1 Method 2 Cremation 3 C

4 Donation 5 Other (Specify) must examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. uss 2262W. signed by the attending physician and completely filled in by the Health and Mental Hyglene prior to burial, cremation, or removal. medicai 23. PART/I. Enter tha disasses, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finsi 140CARDIAC the disesse or condition resulting in death) event. SRON CHIAL traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Diseess or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceues given in Part I. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the HTPENTENSION shows any ATHEMOSCLENOTIC CANDIOVASCULAN DISEAS peen 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\simega \) NO \(\simega \) UNCERTAIN \(\simega \) has by Dept. item 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL s certificate h th the State L d, or item EXAMINER? HOSPITAL:
1 | inpetient 2 | EB/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? with D is marked, 1 Returni 1 YE5 2 NO DIRECTOR: After the hours after death with them 28 is mark BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) COMPLETED 3 Sulcide 8 Could not be 4 Homicide TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 (Check only one) 296. SIGNATURE AND MITLE OF CERTIFIER BE THE Pled 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

10 north Interval Between Onset and Death INFARCTION 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? 1 YES 2 THE 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COM	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detache al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hos	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hos

							95 3	1361
	1 - FOR STATE REGISTRAR	STATE OF MA		ARTMENT OF I	HEALTH AND MEN	NTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle	le, Lest)			2.1	DATE OF DEATH		TIME OF DEATH
	RAYMOND	JAMES	MZ	AZANOWSE		CT 15.	1 Q Q G	2:37 am
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday	y) IF UNDER 1 YEAR	IF UNDER 24 HRS. 7. E	DATE OF BIRTH	8. BIRTHPL	ACE (State or Foreign
	213-18-1304	1 M 2 D F	78 YRS.	MONTHS DAYS	min.	Month, Dey, Year) 1v 18, 191	Country)	SYLVANTA
	9a. FACILITY NAME (If not institution	on, give street and number)		96. CITY, TOWN	OR LOCATION OF DEATH		C. COUNTY OF DEAT	
ECTOR	SAINT JOS	EPH MEDICAL	CENTER	TOWSO	ON, MARYI,	VIND	ד,דתק	יּתס∩אַדי
Ä	10a. STATE 10b.	COUNTY	10c. C	TY, TOWN OR LOCA	TION		10	d. INSIDE CITY
PH	MARYLAND B	BALTIMORE		LUTHERVII	J.E		1	LIMITS?
AL	10e. STREET AND NUMBER				H. ZIP CODE	-10	0g. CITIZEN OF WHA	
FUNERAL	1200_0a	kcroft Drive			Luthervil	10	USA	
5	11. MARITAL STATUS	12. WAS DECEDENT EV		13. WAS DEC	CENDENT OF HISPANIC O	RIGIN? (Specify Yes or	No- 14. RACE -	American Indian,
2	1 Never Married 2 Marrie 3 Widowed 4 Divorced	IF YES, GIVE WAT	OR DATES		pecify Cuban, Mexican, Pu S 2 NO Specify:	erto Rican, etc.)	Black, V Specify:	Mite, etc.
- 4		I W.W. I	_		X	<u> </u>	WHI	TE
COMPLEIED	15. DECEDENT (Specify only high)	T'S EDUCATION est grade completed)	(Give kind o	'S USUAL OCCUPATE of work done during me		16b. KIND OF BUSINE	ESS/INDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)		use retired.)				
1	12 17. FATHER'S NAME (First, Middle, I	n/a	Pro	oprietor		Gas Stat		
_					18. MOTHER'S NAME (F	First, Middle, Maiden Surr	name)	
4	LUCISLAS (W	alter) Mazano				Endrasjik		
2		*			and Number or Rural Route			
	Patricia Dea	ne Matczuk	20b. PLACE AND DATE		Rd. Luth			
	1 Donation 5 Other (Special						TION — City or Town,	State
	21. SIGNATURE OF PLANERAL SERV		Dulaney V	ALLEY Me	em. Gardens (OCT Timor	nium, MD	
- 1	Duy	anti-Ull	M		on Funeral		ılanev Va	llev. Inc.
4	-	Bryan W. Clar	/	10 W	Padonia R	d Timoni	ium MD 2	
	23. PART I. Enter the disease shock, or heart	es, or complications that ca allure. List only one cause	used the death. Do	not enter the mo	ode of dying, auch as	cardiec or reapirate	ory arrest,	Approximata Interval Batween
	IMMEDIATE CAUSE (Final							Onset and Death
	disease or condition resulting in death)	*FUMOR	LYSIS S	YNDROME				1 Week
ļ			AS A CONSEQUENCE					
2	Sequentially list conditions,	0.	C LYMPHO		EUKEMIA			4 vears
	if any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE	OF):				
2	CAUSE (Disease or injury	C	12 4 CONTROLIENCE					
	that initiated events resulting in death) LAST	DOE TO (OR	AS A CONSEQUENCE	OF):				
		d						
	PART II. Other aignificent co	nditions contributing to dec	th but not reaulting	In the underlyin	g ceuse given in Part	I. 24a. WAS AN AUT		RE AUTOPSY FINDINGS
3						PERFORMED		MPLETION DF CAUSE
						1.0 1.0 1.4	OF OF	DEATH?
	DID TOBACCO USE C	ONTRIBUTE TO CAUS	E OF DEATH Y	ES NO T	UNCERTAIN [ור		123 2 10
Ž	25. WAS CASE REFERRED TO MED	DICAL		ATH (Check only one)		-		
4 H	EXAMINER?	HOSPITAL:		OTHER:				

1 TYES 2 NO 27. MANNER OF DEATH

1 Natural 5
2 Accident
3 Suicide 8

Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO 28s. PLACE OF INJURY — At home, larm, street, lactory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

out

DESCRIPTING PHYSICIAN: To the best of my knowledge, death occurred at the Ilme, date and place, and due to the cause(s) and manner as stated.

Image: MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the cours

mination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER H 43974 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR ALICE HSIEH, M.D. 7620 YORK ROAD TOMON MADVI,AMD 27204

31. DATE FILED (Month, Day You)

OC 1 0 1995 32 REGISTRAR'S CHATURE

5 Pending Investigation

8 Could not be determined

4 Homicide 29a. CERTIFIER

(Check only one)

9

000

Epa

CATHERINE

burial-transit permit. Pages 1, 2, 3 should

physician.

ad by

BALTIMORE, MARYLA

Item1,g-728,10-18-95,perf.h.,dk FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)

A L FRED 2. DATE OF OEATH 3. TIME OF DEATH OCTOBER 16 TH 1993 MEYERS 9:03A Joseph 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
April 7, 1915 6. AGE (In vrs. lest birthday) 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 🕅 M 2 🗆 F 219-18-2369 80 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Baltimore City N/A Good Samaritan Hospital RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Middle River Maryland Baltimore 1 YES 2 NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f, ZIP COOE 10e. STREET AND NUMBER 4014 Keener Road 21220 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 Y YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

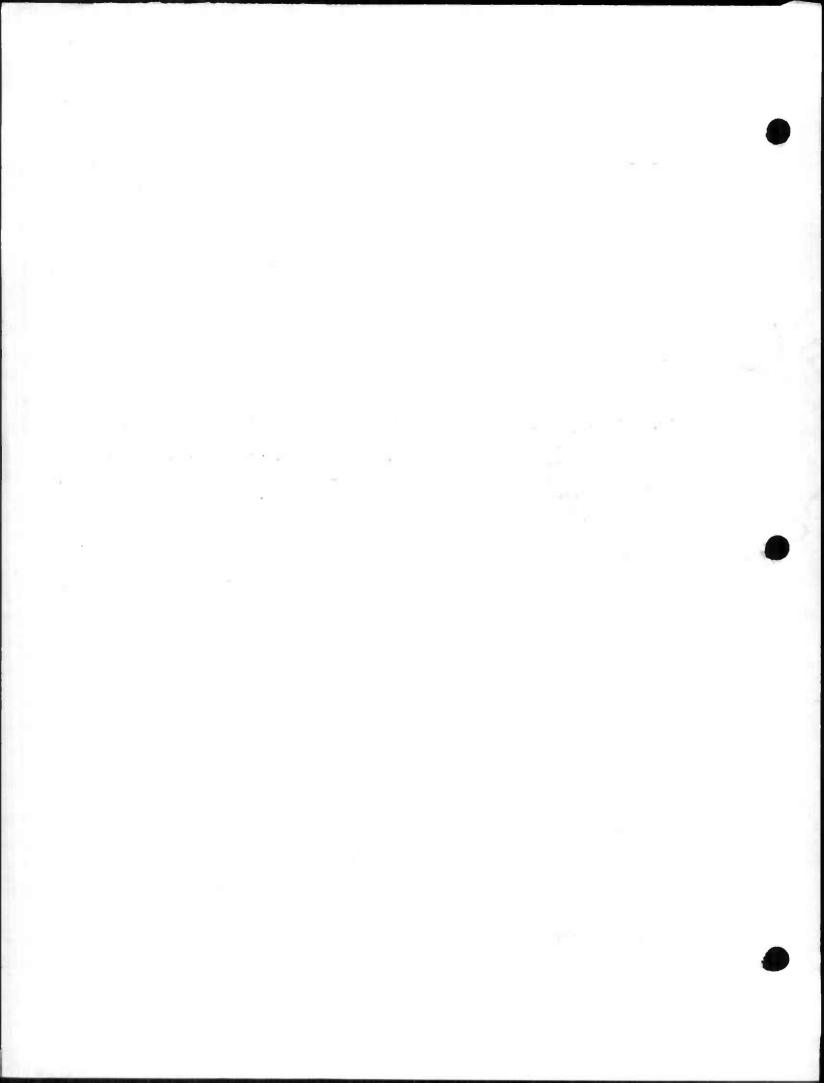
1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married 3 Widowed 4 Divorced WWII White ED 16a. DECEDENT'S USUAL OCCUPATION
(Olive kind of work done during most of working life. Do NOT use retired.) ts. OECEDENT'S EDUCATION (Specify only highest grade complete 16b, KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Liquor Store Clerk 17, FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Oscar Meyers Mary Weber BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4014 Keener Road Middle River, Maryland Mr. William Meyers 21220 20a METNOD OF DISPOSITION

K Burial 2 Cremetion 3 Removal from State OATE 20c. LOCATION — City or Town, State Sacred Ht. Of Jesus Cem. 10/19/95 Dundalk, MD 4 ☐ Donation S ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SONICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda→Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate ahock, or heart fallure. List only one ceuse on each line Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION ONE DAY OUE TO (OR AS A CONSEDUENCE OF): ARTERY DISEASE CORANARY MEDICAL CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO MULTIPLE MYELOMA COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT WORK?
1 YES 2 NO 28a. OATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATN 28d. DESCRIBE NOW INJURY OCCURED 1 Naturel 2 Accident 5 Pending investigation BY 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide 29a. CERTIFIER
(Check only one)

29 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOOD SAM HOSP 5601 LOCAL PAVEN BUILD 21239 00 32 FREDISTRIES SIGNATUR CARLELL DHMH-16 Rev 1/89

DOCT.



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CEN	IIFICA	IE OF	DEATH	REG. NO).		
	1. DECEOENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH	DAY	3. TIME OF DEATH	
	MAJOR T. MACKI	IN SR.					OCT 1		995 1200 P	M
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birth	MONTH	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1937	BIRTHPLACE (State or Foreign Country)	
	227-46-7500	1 💢 M 2 🗆 F:	60 Y	RS.	- United	MIN.		035		
_	9a. FACILITY NAME (If not institution, give s			9b, CI	TY, TOWN	OR LOCATION OF D	EATN	9c. COU	INTY OF DEATH	
DIRECTOR	JOHNS HOPKINS PRESIDENCE OF DECEDENT	HOSPITAL I	E.R.	E	BALT	IMORE C	ITY		N/A	
REC	10e. STATE 10b. COUNT		100	c. CITY, TOWI					10d. INSIDE CITY LIMITS?	
	MARYLAND	N/A		В	ALT.1	MORE C	Т.Т. Х		1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 2701 E. FEDERA	L ST.			10	21213	3	10g. CIT	U.S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT EVI		1			NIC ORIGIN? (Specify Y	es or No-	14. RACE — American Indian, Black, White, etc.	
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X Y IF YES, GIVE WAR O				S 2 NO Specific	nn, Puerto Rican, etc.) ly:		Specify: BLACK	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		(Give kir	ENT'S USUAL	ne during m	ION ost of working	16b. KIND OF B	USINESS/INI	DUSTRY	
LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ine. Do f	MECH			CELE	DMDI	OVED	
ME	8TH 17. FATNER'S NAME (First, Middle, Last)	N/A		MECH	ANIC				LOYED	\dashv
	ALEX MACKI	TN				- 11	NE SMITH	n Surname)		
8	19a. INFORMANT'S NAME (Type/Print)	111/	405 144	II INC ADDR	FDC /000004	1	Route Number, City or To	. 0 7/		\dashv
5	MAGGIE MACKI	.TN					ST. BALT			
	20a, METHOD OF DISPOSITION	1	20b. PLACEAND						- City or Town, State	
	1 Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)			RKS Place	CEM.	oct. 2	21, 1995		ACEY, VIRGIN	IA
	21/SGNATURE OF FUNERAL SERVICE LA	CENSEE			CAI		SCRUGGS		ERAL HOME	
	23. PART I. Enter the diseases, or	rugu	12	7.	1.412				ALTO, MD. 2121	3
	ahock, or haert feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. A THEY	n each line.	none					Interval Betwee	
ATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING	b. DUE TO (OR	AS A CONSEQUEN	ICE OF):						
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST	DUE TO (OR	AS A CONSEQUEN	ICE OF):						
S		a								
EDICAL	PART II. Other eignificent condition	ns contributing to deal	th but not resul	iting in the	underlyle	ng ceuee given in		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME							7000	Peur		
	DID TOBACCO USE CONT	RIBUTE TO CAUSI	OF DEATH	YES 🗆	NO E	UNCERTAL	N 🗆 Th?	r eoi n	, 9	
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITA	28. PLACE OF)				
SIC	1 YES 2 □ NO	HOSPITAL: 1 □ Inpetient XIXER/	Outpatient 3 🗆 C	OOA 4 1		me 5 🗆 Residence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJU (Month, Day, Ye		b. TIME OF INJURY	28c. IA	JURY AT ORK?	28d. DESCRIBE HOW	INJURY OC	CURED	
B≺	1 Natural 5 Pending 2 Accident Investigation			. М	1 🗆	YES 2 NO				
ED	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJ building, atc.	URY — At home, (Specify)	term, street, t	actory, off	ca	261, LOCATION (Stree City or Town, Stell		er or Rural Route Number,	
COMPLET	one)	ICIAN: To the beat of my k							ated.	
	296. SIGNATURE AND TITLE OF CENTIFIE	R 14 AO				29c. LICENSE NU	MBER	29d, DA	TE SIGNED (Month, Day, Year)	\dashv
TO BE	Mayrie M	e Mull				O.C.M			CT. 17,1995	
	MANYDOWAS P. 1				tree	t, Balt	imore, M	laryl	land 21201	
	OCT 1 8 1995	32. A FGISTRAH'S	MATURE							



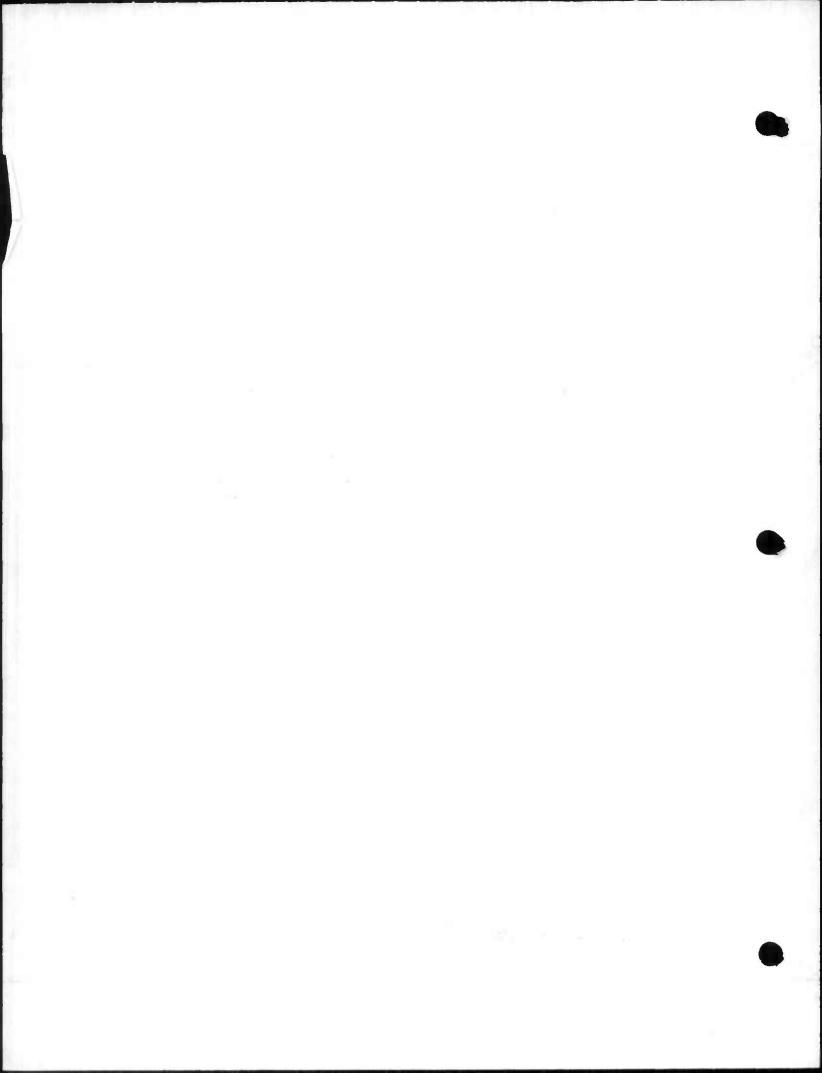
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transf permit. Pages 1, 2 show		
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HOSPITAL OR ATTENDIN	IRECT	e filed within 72 hours after death with the	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - STATE REGISTRAR	OINIE OI MAIIII	CERTIF	ICATE OF	DEA.	AND I	MENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN			3. TIME OF DEATN	
	Mary E. Merson						Octobetr	15,1	995	4:00 A	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8, BIRTH	NPLACE (State or Foreign	
	-10 10 7251 5	1 🗌 M 2 🏋 F	79 YRS.	MONTHS DAYS	HOURS	Merre.	June 23,	1916	Mar	ÿland	
8	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 20 Skipjack Court Essex Baltimore										
СТОВ	RESIDENCE OF DECEDENT										
DIRE	Maryland B	altimore		y, town on loca Essex	TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
ERAL	10a STREET AND NUMBER 20 Ski	pjack Court		10	of. ZIP COD		221		S.A.	WHAT COUNTRY?	
FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED				IC ORIGIN? (Specify Ye		14. RACI	E — American Indian,	
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	DATES		S 2 NO		n, Puerto Rican, etc.)		Spec	k, White, stc.	
8 8	Λ									White	
ETE	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPAT	ION ost of workin	ng	16b. KIND OF BU	ISINESS/INC	DUSTRY		
	Elementary/Secondary (0-12) unknown	College (1-4 or 5+)	Homemak	,			Own I	Jome			
COMPL	17. FATHER'S NAME (First, Middle, Last)		Homemak	C I	16 MOTI	NED'C NA	ME (First, Middle, Maider				
Ш	George W. Sm	ith					. McKnew	r Surneme)			
<u>B</u>	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street				vn. State. Zic	Code		
TO BE	Denise A. Torr	es					Route Number, City or Town, State, Zip Code) sex, Maryland 21221				
	20a. METNOD OF DISPOSITION 1. Burlal 2 Cremation 3 Remov. 4 Donation 5 Other (Specify)	al from State co	b. PLACE AND DATE	ther place!		10	DATE 20c. LC				
	21. SIGNATURE OF FUNERAL SERVICE LICER		readowr 1d					cr rag	e, m	aryland	
	A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave., Baltimore, Maryland 2121										
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): A 1 kerr S Clentic Cardio V ascella Clenause DUE TO (OR AS A CONSEQUENCE OF): d.										
MEDICAL	PART II. Other algnificent conditions						1 YES :	RMED?	24b.	WERE AUTOPSY FINDING AMAILABLE PRIDE TO COMPLETION OF CAUSE OF DEATH?	
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE C			UNC	ERTAIN					
Si Si	EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:	5 To 100	_					
PHYSICIAN:	1 (g) YES 2 NO 1	28s. DATE OF INJURY	patient 3 DOA 28b, TIM		JURY AT	sidence	Other (Specify)	INI MIRRIE D. T.	Mines		
	1 Netural 5 Pending	(Month, Day, Year)		URY W	DRK?	ומו	28d. DEŞCRIBE HOW	MJUHT OC	JUNED		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined determined determined investigation M 1 YES 2 NO 28s. PLACE OF INJURY — At homs, farm, atreet, factory, offics 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								loute Number,		
ETE	20. CERVIEUR										
COMPL	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my know On the basis of exemination) and menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	\			29c. LICE	NSE NUM	BER	29d DATI	SIGNED	(Month Day Year)	
) BE	50	lenne	mn			1)3	0641	•	(0)	17195	
2	30. NAME AND ADDRESS OF PERSON WHO (COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print) 308	821	· av	· Eutau	ist 1	Ball	17198 Incmp21.	
	31. DATE FILED (Month, Ony, Year) OCT 1 & 1995 July	28 DECRETO A DIOCENTA	ATUBE								

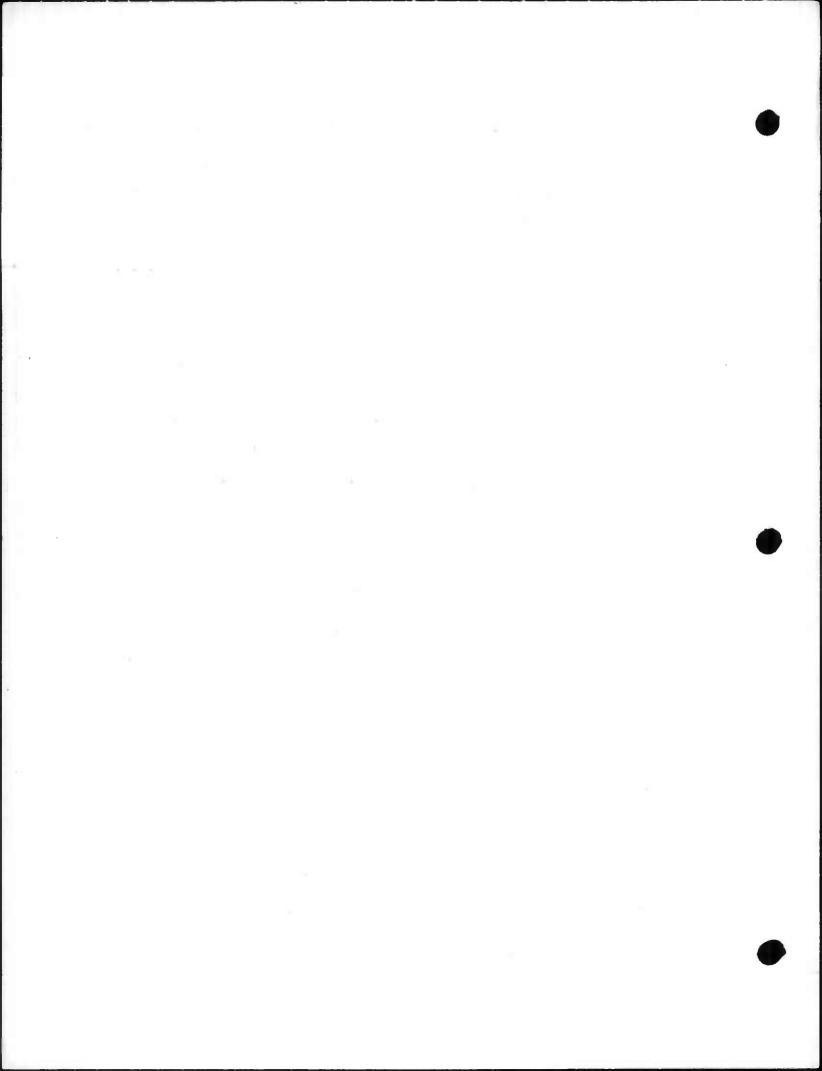


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

7	REGISTRAR		OLITIII	TOMIL	OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last,	4				2. DATE OF DEATH MONTH DA		PASY	IME OF DEATH
		liam A. Meye					995	5	:45 A M
	4. SOCIAL SECURITY NUMBER 216-01-2030	1 M 2 D F	(In yrs. leat birthday) 82 YRS.	IF UNDER 1 YE MONTHS DA		7. DATE OF BIRTH (Month, Day, Year) May 4, 19		Country)	E (State or Foreign
Œ	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TO	WN OR LOCATION OF DE	ATH	9c. COUNT	Y OF DEATH	
1 9	Meridian Multi	Medical		Tows	son		Ba1t	imore	
2	10e. STATE 10b. COUN	TY	10c. CIT	Y, TOWN OR L	OCATION			10d.	INSIDE CITY LIMITS?
		timore	To	wson					YES 2 📉 NO
FUNERAL DIRECT	10e. STREET AND NUMBER				10f. ZIP CODE			N OF WHAT	COUNTRY?
W W	7700 York Road	12. WAS DECEDENT EVER	IN II C A DIAFO	1 40 1110	2120		U.S.		34
교	1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes	DECENDENT OF HISPAN	n, Puerto Rican, etc.)	or No —	Black, Whi	mericen Indien, Ite, atc.
6	3 Wildowed 4 Divorced	IF TES, GIVE WAR ON I	DATES	''	YES 2 NO Specify	<i>!:</i>		Specify:	hite
TED	15. DECEDENT'S ED (Specify only highest grad		16e. DECEDENT'S	work done durin	PATION g most of working	166. KIND OF BUS	SINESS/INDUS	STRY	
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once.			Painter	c		Fisher		GMC	
4	17. FATHER'S NAME (First, Middle, Last) George Henry	Mevers			Rose Red	ME (First, Middle, Maiden 1mon	Sumame)		
B 8	19e. INFORMANT'S NAME (Type/Print)	neyers	19b. MAILING	ADDRESS (Str	reet and Number or Rural I		n State 7in C	note)	
	Donald Meyer	S			ard Street				21211
e d	20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITIO	N (Name of		CATION — CH		
must	1 Donetion 6 Other (Specify)	Po	oplar Gro	ove Cen	netery 10,	/17/95 Pho	enix,	Mary	land
examiner	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE			le and address of FA		ral Ho	mo	
1000	Mallan	· Seit	Sh		Roland Av				nd 21211
event, the medical	23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. List only one cause on	aach lina.	^	moda of dylng, auc			Q	Approximate Interval Between Onset and Double
or other traumatic or STIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	CONSEQUENCE OF	n _F					
3	PART II. Other significant condition	ne confributing to death	but not resulting	in the under	lying cause given in	Part I. 24a. WAS AN			E AUTOPSY FINDINGS ABLE PRIOR TO
amy Dic.	1000	nau	Can	re	\	1 □ YES 2	/	COM	PLETION OF CAUSE
No.	CV				_/_		-		YES 2 NO
23 s	DID TOBACCO USE CON	TRIBUTE TO CAUSE O		***		10			
ed, or Item 23 sh PHYSICIAN: N	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES TWO	HOSPITAL:	26. PLACE OF DEA	OTHER:	- Carlo	Canal St. Later Consumer			
HYS	27. MANNEY OF DEATH	1 D Inpetient 2 D ER/Out 29s. DATE OF INJURY	petient 3 (.) DOA 28b. TIM		Home 5 Residence	6 C) Other (Specify) 284. DESCRIBE HOW II	FRIBA OCCUI	BED.	
45	1 Sectoral 5 Pending	(Month, Day, Mar)		URY	WORK?	The state of the s		-	
	2 Accident Investigation 3 Suicide 6 Could not be 4 Hamilcide deformined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, soily)	street, fectory.	office	28f, LOCATION (Street a City or Then, State)	nd Mumber or	Plural Ploute I	Yumbec
200									
Item 28 PLETE	20a CERTIFIER	SICIAN: To the best of my know	wiedge, death occurr	ed at the time,	date and place, and due	to the cause(e) and man	ner as stated.		
If item 28 i	20a CERTIFIER	SICIAN: To the best of my know			date and place, and due on, death occured at the				manner as stated.
PORTANT: If item 28 I	290. CERTIFIER (Check only					time, date end place, en		ceuse(s) end	manner as stated.
PORTANT: If Item 28 I	29e. CERTIFIER (Check only 100 MEDICA) EXAMIN 2 MEDICA) EXAMIN 29b. BIGNATURE AND TITLE OF CERTIF	to the beels of examination		on, in my opinic	29c. LICENSE NUM	time, date and place, and time.	29d. DATE S	GIGNED (Form	10
PORTANT: If Item 28 BE COMPLETE	290. CERTIFIER (Check only 1 SIGNATURE AND TITLE OF CERTIFIE	to the beels of examination	on end/or investigation	on, in my opinic	on, death occured at the	time, date and place, and time.	d due to the o	GIGNED (Form	10



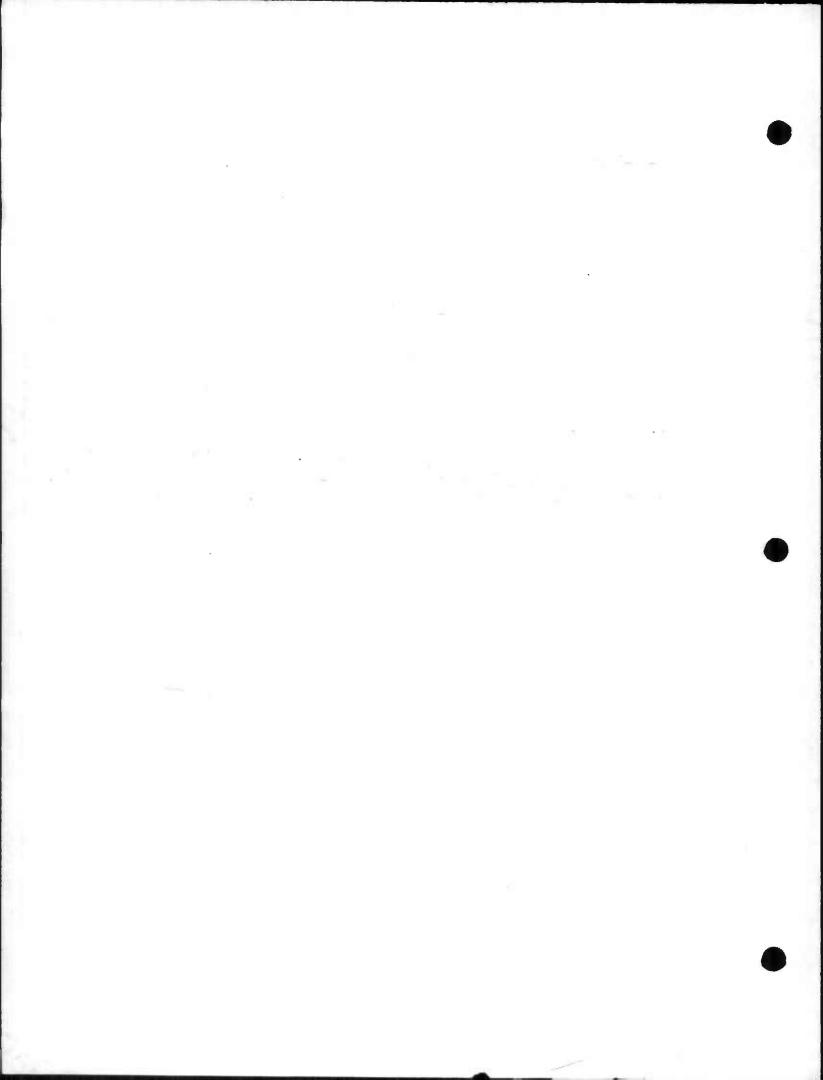
BALTIMORE, MARYLAND 21215-0020
ther death. Pace 6 may be retained by the hospital or attending physician.

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 5 should be defacthed for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF N					EALTH AND I	MENTAL	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF DEATH	ıv	YEAR	3. TIME OF DEATN	
	VICTOR	AMOS		NORT	HINGT	ON			DBER I			3:33A	М
	4. SOCIAL SECURITY NUMBER 425-44-0083	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH Day, Year) 7,19	128	Count	NPLACE (State or Forel try) Sissippi	gn
	9e. FACILITY NAME (If not institution, give st		07		Bh CITY	TOWN	R LOCATION OF DE		. /, 17		UNTY OF		_
OR BO	THE JOHNS HO		SPITAL				ORE CIT			50.00	JIII OF I	N/A	
DIRECTOR	100. STATE 10b. COUNTY Maryland	Baltimo	re	10c. CIT	Y, TOWN O	R LOCAT	Edg	gemer	e			10d. INSIDE CITY LIMITS? 1 YES 2 N	0
A.	10e. STREET AND NUMBER					101.	ZIP CODE					WHAT COUNTRY?	
E	2928 Delmar Aver	iue					2	1219		un	ited	States	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W			11	yes, spe	ENDENT OF HISPAI icity Cuben, Mexica 2 NO Specifi	in, Puerlo F	? (Specify Yee licen, atc.)	or No-	14. RAC Slec	E — American Indian. ck, White, atc. city: White	
0	15. DECEDENT'S EDUC		16a. DE	CEDENT'S	USUAL OC	CUPATIO	IN .	16b.	KIND OF BUS	SINESS/IF	OUSTRY		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	Hila	iive kind of . Do NOT u	work done d se retired.)	uring mo:	st of working						
2	12 Years	Conege (14 or 3	"	Wel	der					Stee	e In	dustry	
<u>8</u>	17. FATNER'S NAME (First, Middle, Lest)						18. MOTNER'S NA	ME (First, A	Aiddie, Meiden	Surneme)			
E C	Roy Braxton North	hinaton					Fanni	e Au	aline	Brou	m		
00	19e. INFORMANT'S NAME (Type/Print)	00/10/100/1	19	b. MAILING	ADDRESS	(Street e	nd Number or Rural	Route Numl	per, City or Tow	n, State, 2	(ip Code)		
2	Mrs. Evelun G. No	orthinate	on	29	28 De	lma	r Avenue	Bal	timore	, MI	21	219	
	204. METNOD OF DISPOSITION		20b. PLACE	ANDDATE	OF DISPOSI	TION (Na	me of	OAT	E 20c. LO	CATION -	- City or T		
	1 X Burial 2 Cremetion 3 Remo	oval from State	Gando	matory or o	ther place)	th	Cem. 10/	19/9	5 Ba	ltin	nore,	Maryland	1
	21. SIGNATURE OF FUNDAL BERVICE LIC	DILLE / Y	011									lalk, Inc.	
	1 1/2 //2	1/	1/		1)uda	-Kuck tu	mera.	c Home	.00	buna	iack, inc.	
_	04/11	110	1		-		Wise Av				_		
	23. PART I. Enter the diseases, or cahock, or heart failure.	complications the	taused the de	eath. Do	not entar	tha mo	da of dying, suc	ch aa card	flac or reap	iratory a	rreat,	Approximat interval Bet	
	IMMEDIATE CAUSE /Finel						1	3				Onset and	Daeti
	disease or condition resulting in death)	a. Olio	61951	On	20	m	U/tit	051	ne			6 iver	eks
		DUE TO	(OR AS A CONSE	OUENCE C	OF):		· ·						
Z	Sequentially list conditions,	b											
CERTIFICATION	If any, leading to immediate	DUE TO	(OR AS A CONSE	QUENCE C	OF):								
2	CAUSE (Disease or Injury	с.											
E	that initiated events resulting in death) LAST	506 10	(OR AS A CONSE	OUENCE C	<i>ነ</i> ተ):								
5		d											
- 1	PART II. Other eignificant condition	a contributing to	death but not	reaulting	in the un	darlyin	g cause given in	Part i.	24a. WAS AN		Y 24	b. WERE AUTOPSY FIN	
CA									1 YES			AVAILABLE PRIOR TO COMPLETION OF CA	
PHYSICIAN: MEDICAL									A	1		1 YES 2 X NO)
≥	DID TOBACCO USE CONTI	RIBUTE TO CA	AUSE OF DEA	ATH Y	ES 🗆 N	10 1	UNCERTAI	ΝП				7	
AN	25. WAS CASE REFERRED TO MEDICAL				ATH (Check		1 01100111111			-			_
Sic	EXAMINER?	HOSPITAL:	☐ ER/Outpatient :	3 DOA	OTHER 4 Num		e 5 🗆 Reeldence	6 🗆 Othe	r (Sneothy)				
H	27. MANNER OF GEATN	28e. OATE OI		28b. TII		28c. INJ			SCRIBE NOW	INJURY C	CCURED		_
	1 Natural 5 Pending	(Month, I	Day, Year)		JURY	WC	PRK?						
ВУ	2 Accident Investigation	28e. PLACE	OF INJURY — At he	ome, farm,	street, fact			28f. LOC	ATION (Street	end Numl	per or Rural	l Route Number,	
ED	3 Suicide a Could not be 4 Homicide determined	building	, etc. (Specify)						or Town, Stete				
COMPLETED	290, CERTIFIER						22-22-2-32	Self in			22/11		
MP	(Check only	ICIAN: To the best o											
00	2 MEDICAL EXAMINE	:H: On the beele of	examination end/or	investigati	ion, in my o	pinion, d	earth occurred at the	e time, dete	ena place, er	nd due to	the ceuse	(e) end manner ee sta	red.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	3.0 -	0				29c. LICENSE NU	MBER		29d. D.	ATE SIGNE	ED (Month, Day, Year)	-
OB	chetchen L	who, Ir					1024	42		[Scto	ober 16,1	193
	I SO MANUE AND ADDRESS OF BERGON WAS	O COMBI ETEC OU	ICE OF OPATH ST	ERA 020 /T -	- Outst							7	



3. TIME OF DEATH

2. DATE OF DEATH DAY YEAR Margaret Otto R. Oct. 16, 1995 9:00 A. M 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Dey, Year B. BIRTHPLACE (State or Foreign DAYS 82 1 M 2 F 215-01-9523 Maryland Vov.3,1912 -transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 600 Light St. Apt.218 Balto.City, Md. none RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Balto.City, Md, none 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 600 Light St. 21230 United States Apt. 218 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THOU IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuban, Mexican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 TES 2 NO Specify: B 3 Widowed 4 Divorced 8 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Hecht Co. 12th, Grade none 17. FATHER'S NAME (First, Middle, Last) BALTIMORE, MARYLAI 16. MOTHER'S NAME (First, Middle, Maiden Surname) the retained by ti 2 Rose Ħ Otto Phelps Juluis BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21202 100 Light St.Balto.Md. Barbara Ann Spicer hours after death. Page 6 may be pe 20a. METHOD OF DISPOSITION
1 Description | Method | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Description | Descri 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Balto. City, Md. DATE must 1 Donation 1 Other (Specify) Loudon Park Cemt. 10/19/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave n by the removal. the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory arrest, shock, or haart failure. List only one cause on each line. in and completely filled in to burial, cremation, or re Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) (ANDIA(ALLYTHMIA 1+0 M traumatic event, executed with DUE TO (OR AS A CONSEQUENCE OF): BOX 68760 ANTERY DISEASE OLONALY CERTIFICATION Sequentisliy list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a ental Hygiene prior to If any, isading to immediata cause. Enter UNDERLYING STEROIIS requires that the death certificate be ONT CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): P.O. I that initiated events resulting in death) LAST 6 the attend DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS the been signed by the pt. of Health and N AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 TYES 2 400 1 YES 2 NO has be Dept. (DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law ITO THE FUNEPAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Itom 28 is marked, or Itom 23 is 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28a. DATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

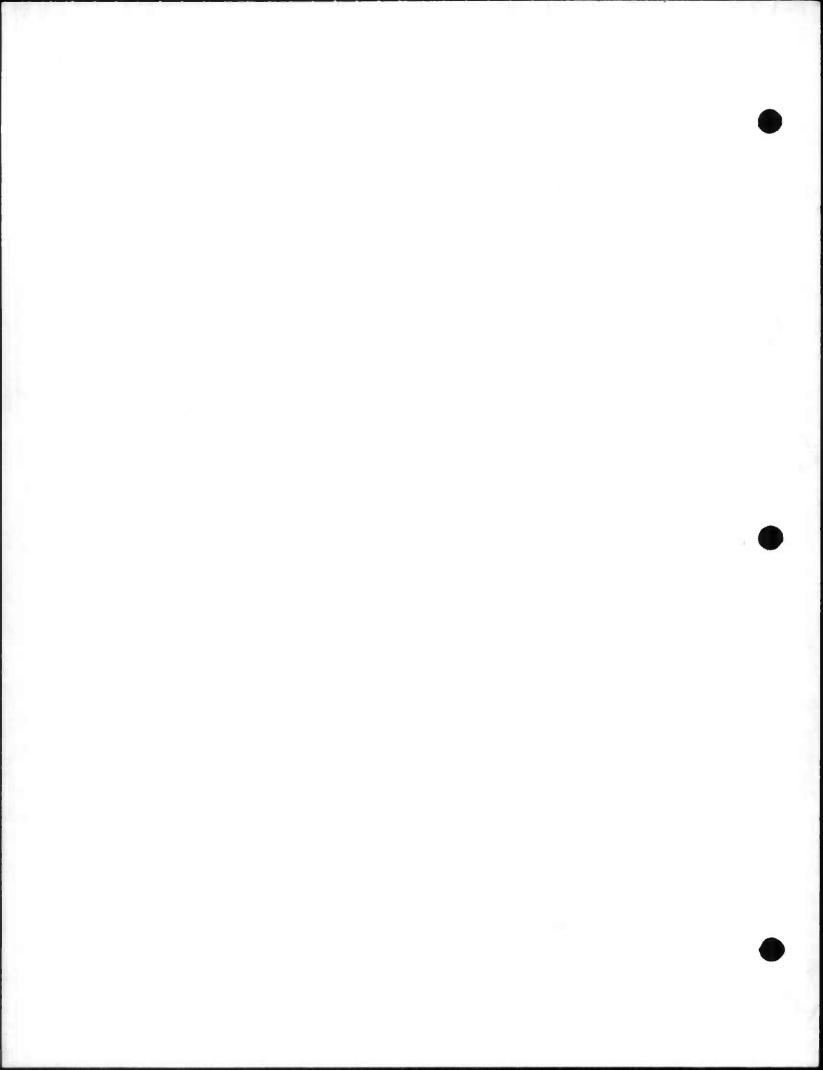
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 119640 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAR HMOVER 31. DATE FILED OC

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last)

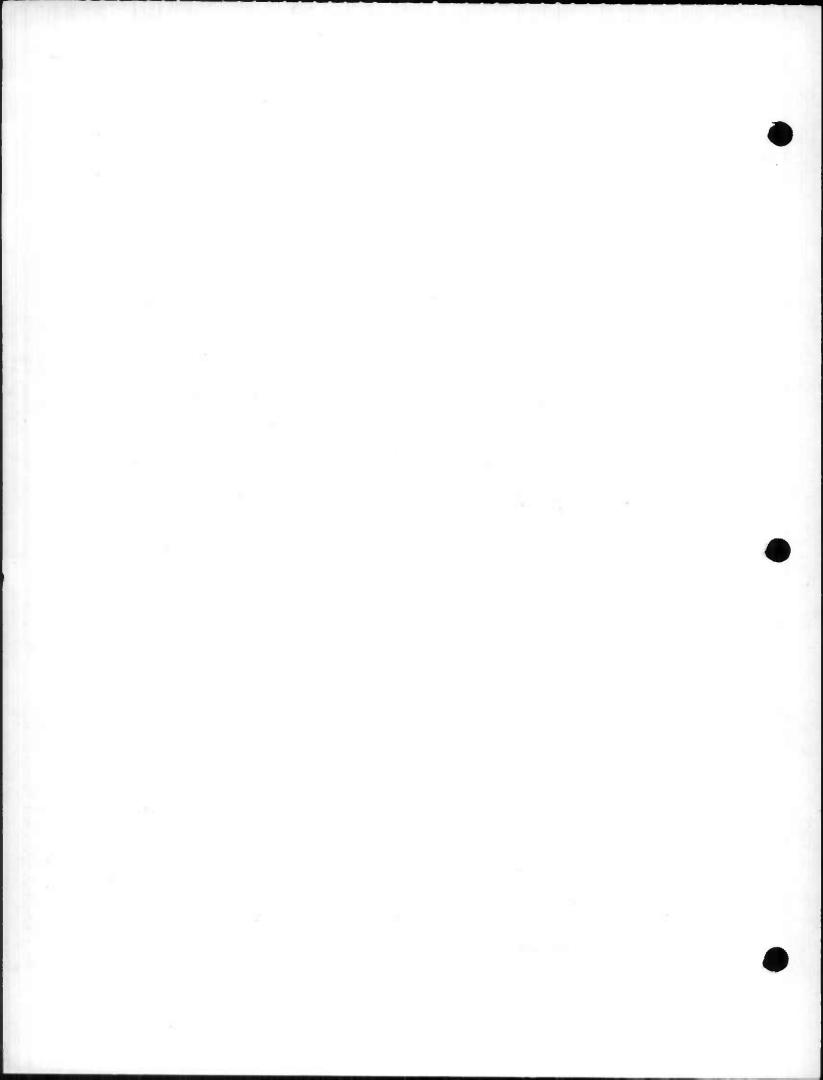
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.O. 8C	certificate
J.	death
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MECO	requires t
AL	The law
2 7	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24
5	HO
4	HOSPITAL OF

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART				YGIENE			
	1. DECEDENT'S NAME (First, Middle, Lest) YVONNE	OREM				2. DATE OF MONTH	DEATN DAY	1995	AR	38 PM M
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTN sy, Ybar)	8.6	BIRTHPLACE Country)	(State or Foreign
	267–15–6158 9e. FACILITY NAME (If not institution, give st	1 M 2 XF 47	YRS.		OR LOCATION OF DE		er 12.	1947 9c. COUNTY		York
DIRECTOR	7217 Meadow Wood Way			Clarks	rille			Howar	rd	
EC	10a. STATE 10b. COUNTY	,	10c. CITY,	TOWN OR LOCA	TION				10d. II	NSIDE CITY
	Maryland Howai	rd	Cla	rsville					1 🗆 '	YES 2 NO
RA	7217 Meadow Wood Way			10	21029			109. CITIZEN	OF WHAT C	JUNIATY
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U		13. WAS DEC	ENDENT OF NISPAN	IIC ORIGIN? (S	Specify Yes o		RACE Am	erican Indian,
BY FL	1 Never Married 2 Married 3 Wildowed 4 1 Divorced	FORCES? 1 YES		If yes, sp	ecify Cuban, Mexical 2 NO Specify	n, Puerto Rice			Specify: So	uth
60	15. DECEDENT'S EDUC (Specify only highest grade	CATION 1	Se. DECEDENT'S U	SUAL OCCUPATION And Author Michael Mi	ON .	16b. KI	ND OF BUSI	NESS/INDUST		11
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	TOTAL -			(aquita	er Scier	nce	
OM	17. FATNER'S NAME (First, Middle, Last)			CIL IQUIC	16. MOTHER'S NA	ME (First, Mide	die, Meiden S	urneme)		
BE C	Mario Solorzano		1.4		Tina Est	rada				
TO B	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural F					
-	Marc Jason Orem				d Way Clark		_			
	20a, METNOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	oval trom State camete	ery, crematory or oth	er placa)		-16-95	100	ation - city		
	21. SIONATURE OF FUNERAL SERVICE LIC			22. NÂME A	ND ADDRESS OF FA	CILITY				
	1/1) A.	1 -1			ack Funeral Licott City					
	23. PART I. Enter the diseases, or o							atory arrest		Approximate
	IMMEDIATE CAUSE /Final	List only one cause on eac								Interval Between Onset and Death
	disease or condition resulting in death)	. Inclast	atic	Pana	reetic	. C	anc	اسا		MONTHS
		DUE TO (OR AS A C	ONSEQUENCE OF)	:						
ON	Sequentially list conditions,	b. DUE TO (OR AS A C	ONSEQUENCE OF							
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING	00E 10 (0h ka k 0	ONSECOENCE OF							
IFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF)	:						
H	resulting in deeth) LAST	d						- 4		
	PART II. Other significant condition	s contributing to death but	not resulting in	the underlyin	a cause given in	Part I. 2	sa. WAS AN	WTOPSY	24b. WERE	AUTOPSY FINDINGS
CAL	NIA						PERFORI	WED?	AWAILA	ABLE PRIOR TO LETION DF CAUSE
ED						— '	YES 2	KI NO	OF DE	YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES	I NO F	UNCERTAIL	NIX			NI	-
IAN	25. WAS CASE REFERRED TO MEDICAL		. PLACE OF DEATH							,
SIC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpet	lent 3 DOA	OTHER: 4 - Nursing Nor	ne 5 A Reeldence	8 🗆 Other (S	Specify)			
ΉΥ	27. MANNER OF DEATN	28e. DATE OF INJURY	28b. TIME	OF 28c. IN	JURY AT NA	28d. DESCR	RIBE NOW IN	JURY OCCUR	RED	
BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	NI	↑ M 1 🗆	YES 2 NO		NIE	+		
ED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specify	At home, term, st		ce	28t. LOCAT City or	ION (Street at Town, State)	Number or		umber,
COMPLET	290. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my knowled	dge, death occurred	d at the time, dat	e and place, and due	to the cause	(a) and man	ner sa stated.		
OMI	nee!	ER: On the basis of exemination	end/or investigation	, In my opinion,	death occured at the	time, dete er	nd place, end	due to the c	euse(a) and i	menner se stated.
EC	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUI	MBER	T	29d. DATE S	IGNED (Mongl	h, Day, Year)
00	By Krigh	_			D 411	139) 10	114/	95
TO	11065 Lette			Print) Kwa	y, Colu	bic	Un) 2	2104	4
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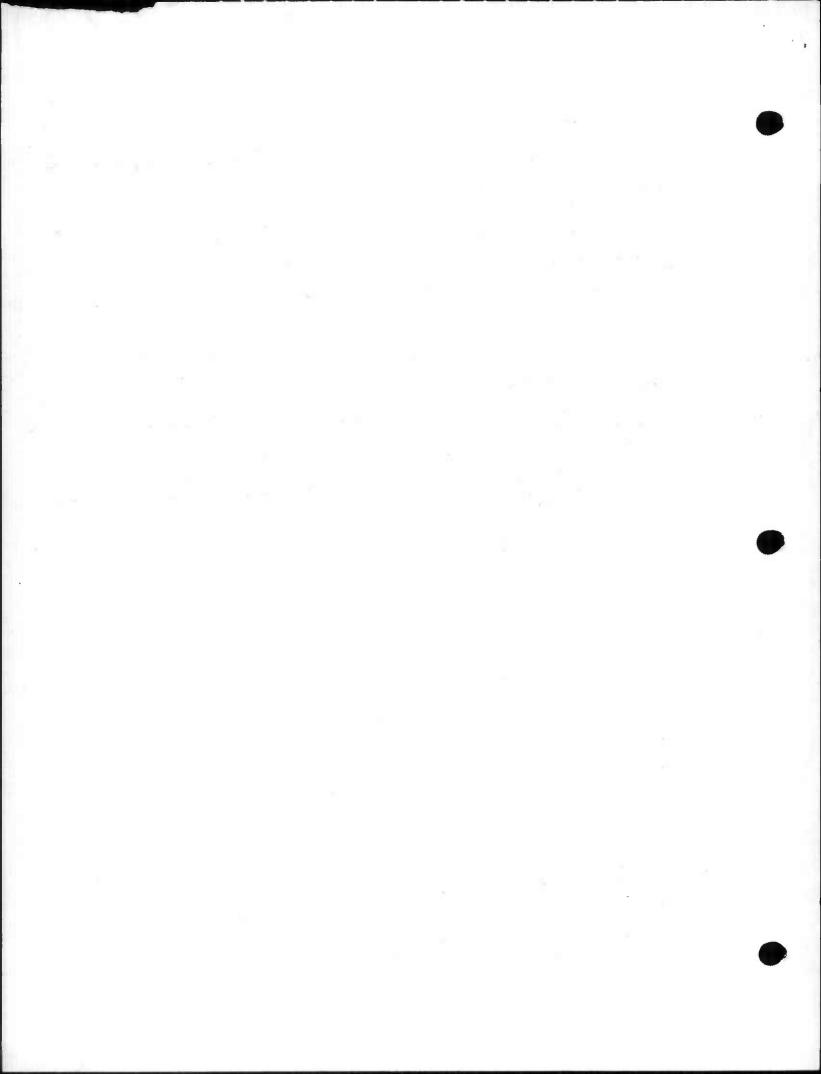


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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 10,1995 Robert PETR MAS October 9:16 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 34, 40 JAC AR Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOSPILE COSSO AL Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ARYLARO 1 YES 2 NO permit. FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? HARFORD ROAD funeral director, page 5 should be detached for use as the burial-transit A1334 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 27 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cubsn, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BΥ 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION ISB. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) 13/18 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname notified at BE INFORMANT'S NAME (Typ 2 10 Page 6 may be 2 20s. METHOD OF DISPOSITION
1 Burlel Commetion 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of OATE. must 4 Don 5 Other (Specify) MAIOR 9.3 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EVAC 4.2 APLLO FORD pletely filled in by the after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death 8 IMMEDIATE CAUSE (Final the cremation, disease or condition Arrhythmia 25 min. event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com E03 CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate the attending physician Mental Hygiene prior to e. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL I Health and I Transient ischemic attack shows any 1 TYES 2 X NO DE DEATH? 1 TYES 2 TNO t. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖾 NO 🗌 UNCERTAIN 🗍 PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? certificate of the State HOSPITAL: OTHER: Inpatient 2 SER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) pe p 0 26s. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28c, INJURY AT 26b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED marked. this 1 Natural М 1 YES 2 NO BY After 1 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: hours after 4 Homicide 28 8 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. (Check only one) FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 7. ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D 43423 10/10 25 2 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Roberts 2000 Franklin Square Dr. Baltimore, Maryland 21237

SALL STREET, SALENCY STREET, S



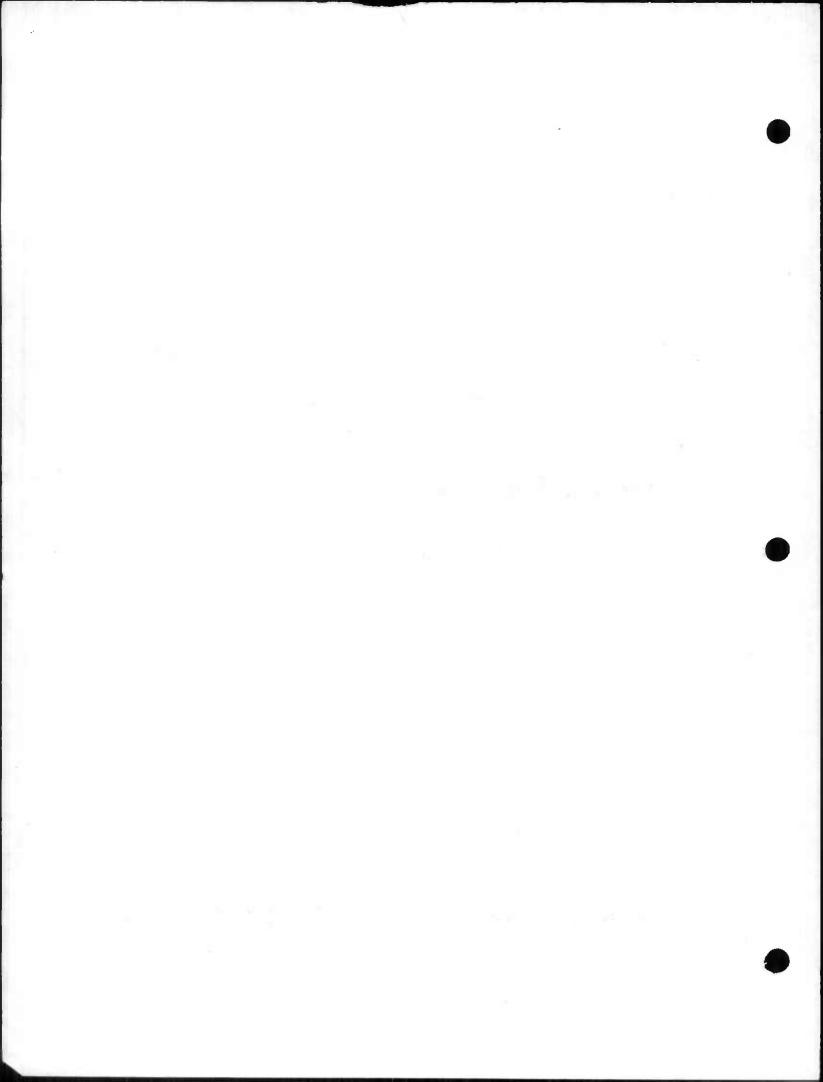
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE	OF MARYL			HEALTH AND	MENTAI	HYGIENE REG. NO.				
	t. DECEDENT'S NAME (First, Middle, La	*	D1 ' 1				MONTH	OF DEATH DAY	YE	AR	. TIME OF DEA	ATH
- 1	Elizabet	n J 5. SEX		brick (In yrs. last birthday)	IF UNDER 1 YEA	IR IF UNDER 24 HRS.	Octo	ber 15			11:05 ACE (State or I	A M
	244-02-3811	1 M 2	100000000000000000000000000000000000000	27 YRS.	MONTHS DAY			, Day, Year)		Country)		
	9e. FACILITY NAME (If not institution, gh	ve etreet end numb	er)	21	9b. CITY, TOV	N OR LOCATION OF D			9c. COUNTY	OF DEA	rolina	
DIRECTOR	Bayview Medical				Balt	more				N/Z	P	
F C	10e. STATE 10b. COU			10c. CI	TY, TOWN OR LO	CATION				10	Od. INSIDE CIT	ſ¥
	MD	N/A			Balt						X YES 2	
HA	100. STREET AND NUMBER	at.				21224			2.5	OF WH	AT COUNTRY?	
FUNERAL	3113 Fleet Stre	t2. WAS DE	CEDENT EVER IF			DECENDENT OF HISPA			USA r No – 14.	RACE -	- American Inc	dlan,
BY	1 Never Merried 2 Married 3 Widowed 4 Divorced		? 1 YES			, specity Cuben, Mexic YES 2 NO Speci		Rican, etc.)		Specify:	White, etc.	
	15. DECEDENT'S E	DUCATION		18e. DECEDENT			16b.	. KIND OF BUSIN	,		INDIAN	
-	(Specify only highest gr Elementary/Secondery (0-12)	College (1-	f or 5+)	(Give kind of life, Do NOT	f work done during use retired.)	most of working						
COMPLEIED	10 17. FATHER'S NAME (First, Middle, Last)	0		Secret	ary			ome Imp		ent		
- 1			T1			18. MOTHER'S NA						
O BE	teo. INFORMANT'S NAME (Type/Print)		Jacol		G ADDRESS (Str	Delor set and Number or Rural			Cklea State, Zip Co			
=	Rodney Jaco					Box 93 Bo						
	20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 R 4 Donation 5 Other (Specify)	emoval from St		netery, cremetory or	other plece)		DAT		TION City		ı, State	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE) ,	edhill C	22. NAN	E AND ADDRESS OF FA			,			
	* Kathleen	a. u	Jelle			vid J. Web				21	1221	
	23. PART I. Enter the diseases, ahock, or heart fallu										Approxir	
	IMMEDIATE CAUSE (Final disease or condition										Onset ar	nd Death
	resulting In death)	a. G	ram pos	consequence	epsis		<u>.</u>				48 h	ours
z	Sequentially list conditions,	ь. А	RDS									
A E	if any, leading to immediate cause. Enter UNDERLYING	D	UE TO (OR AS A	A CONSEQUENCE	OF):							
CERTIFICATION	CAUSE (Disease or injury that initiated eventa	c	UE TO (OR AS A	CONSEQUENCE	OF):							
<u> </u>	resulting in death) LAST	d						-				
AL C	PART II. Other significant condit	tions contribut	ing to death b	out not resulting	in the under	ying cause givan ir	n Part i.	24a. WAS AN A			VERE AUTOPSY	
MEDIC								1 VES 2		C	OMPLETION OF OF DEATH?	
Ž.	DID TOBACCO USE COI	AITDIDLITE TO	O CALISE O	NE DEATH V	EC D NO	UNCERTA	INI D			1	YES 2	NO
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		J CAUSE C	26. PLACE OF DE								_
	EXAMINER? 1 YES 2 NO	HOSPITA 1. Inpetie		patient 3 🗆 DOA	OTHER:	Home 5 Residence	8 🗆 Othe	r (Specify)				
2	27. MANNER OF DEATH 1 Netural 5 Pending		ATE OF INJURY lonth, Day, Year)	28b. Ti	YAULY	INJURY AT WORK?	28d. DES	CRIBE HOW IN.	URY OCCUR	ED		
1 24	2 Accident Investigation 3 Suicide 8 Could not	28e. PI	LACE OF INJURY	/ — At home, ferm		YES 2 NO		ATION (Street an	d Number or	Rural Roc	ute Number,	
LED	4 Homicide detarmined		uliding, etc. (Spe	cify)			City	or Town, Stete)				
29a. CERTIFIER (Check only one) 29a. MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and the time, date en												
5	2 MEDICAL EXAM		sie of exeminatio	on and/or investigat	tion, in my opinie	on, death occured at th						
쀪	296. SIGNATURE AND TITLE OF CERTI	FIER	mo.			29c. LICENSE NU	MBER (DATE S	SNED (A	Month, Day, Yee	r)
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETE	D CAUSE OF DE			onking Pa	uni ou	Modia	ol Cor	tor		
	WA, HOO 9	Epue	ERF GISTRAR'S SIGN		4940° Ea	opkins Ba stern Ave	nue,	Baltim	ore,	ber	21224	
	OCT 1 8 1995		udion R									



BALTIMORE, MAR	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours, after death. Page 8 may be retained	TO THE FUNERAL DIRECTIOR. After this certificate has been signed by the attending physician and completely filled in by the finance checking and 5 shows		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
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П	quire	n Sig	He	10W
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	SNIC	After	Seatt	E
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TEN	DR.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or nemonal	00
<u> </u>	RAT	RECT	urs a	m 2
2	100	T DI	2 00	f ite
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	H	F	WILL	TAN
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ding physician. the burial-transit permit. Pages 1, 2, 3 should

21215-0020

	Item1,g-728,10-18-9	95.perf.h.	. dk						0	5	31371
	FOR 1 • STATE REGISTRAR		MARYLAND / DE	EPARTMEN TIFICAT	IT OF I	HEALTH AN	ID MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					BEATTI	2. DA	TE OF DEATH		3.	TIME OF DEATH
	THOMAS	James	RL	JEFIN .	Sr.		MO	Oct 109	995	YEAR 1	2:41 pm "
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birt	thday) IF UND	ER I YEAR	IF UNDER 24 H	41.4	E OF BIRTH		BIRTHPL	ACE (State or Foreign
	230-01-9759	1 M 2 □ F	75	YRS. MONTHS	DAYS	HOURS M	N.	11th, Day, Year)	120 U	Country)	ilula
	9a. FACILITY NAME (If not institution, give str	reet and number)		9b. Cl7	TY, TOWN	OR LOCATION O	OF DEATH	3.001	9c. COUNT		TH
0 8	Saint Joseph Medic	al Center			Tows	on, Mai	ryland		Bah	timore	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		199	c. CITY. TOWN							
DIRECTOR	Marylano Ra	Hi mur			KE	1 4 3	6			10	d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	14111001	0	1 1	· ·	I. ZIP CODE			to- CITITE	N OF WALA	TES 2 NO
H.	825 Temple Clift RUAD 21208 USA USA										
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian,										
	IF VES CIVE MAD OR PATES										
ВУ	3 Widowed 4 Divorced	WW	工				poony			Bla	ck
BEICOMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of		(Give ki	ENT'S USUAL	e during me	ON ost of working	1	66. KIND OF BUS	SINESS/INDUS	STRY	
13	Elementary/Secondary (0-12)	College (1-4 or 5 +) // // // // // // // // // // // // //	NOT use retired.) j-	1		MASON	n. KE	Sunt	maing
Z.	17. FATHER'S NAME (First, Middle Lest)		Const	vich	nci	191hE	- 5-				Campony
O.	James Pul	90				18. MOTHER'S	S NAME (First	, Middle, Malden			
	19a. INFORMANT'S NAME (Typa/Point)	^-	19b M/	AU INC ADDRE	SE /Street	and Mumber or P	3) 10	mber, City or Tox	25		1500
2	Katherine Ki	- PAIN	83	5 TG	MY	Je C	1,6	Popp	Bal	1 ha	uce me
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo		20b. PLACE AND	DATE OF DISPO	SITION	ame of	a colle	15 / We 10	CATION - CIT	y or Town.	
	1 Donation 5 Other (Specify)	vel from State	Cemetery, cremato	ry or other place	nucl	DI	107	T	MYTU	s bu	anuluan
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSE				ND ADDRESS O	F FACILITY	TAUN F	21018	NSTOL	N RIND
	Delan d	Lune	5	h	ilm	inan	Mari		D. 11		491211-
	23. PART i. Enter the diseases, or co	omplications that	t csused the death,	Do not ente	er the mo	de of dving.	such as ca	ordiac or read	ratory arres	MAR	Approximats
	ahock, or heart failure. L IMMEDIATE CAUSE (Final	ist only one cau	se on each line.						,	.,	interval Between Onset and Death
	disesse or condition	CARDIA	CARREST								Minutes
1 1	resulting in death)	DUE TO	(OR AS A CONSEQUEN	ICE OF):							
z	S (5 b)	SEPSIS									24 Hours
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEQUEN	ICE OF):							
2	CAUSE (Disesse or Injury	DUE TO	OR AS A CONSTOUR	107.00							
E	that initiated events resulting in desth) LAST	DOE 10	(OR AS A CONSEQUEN	ICE OF):							
E E	d.	•									
F	PART II. Other aignificant conditions				ınderiyin	g cause giver	n in Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
MEDICAL	STROKE AFTER CO		BYPASS SUI	RGERY				1 TES 2	100	co	MPLETION OF CAUSE
ME I	HYPERTENSION, DI										YES 2 NO
z l	DID TOBACCO USE CONTR	IBUTE TO CA				UNCERT	AIN 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE							
YS	1 □ YES 2 PHO	T	ER/Outpatient 3 🗆 🗅	DOA 4 II No	roing Hon	e 5 🗆 Resider	nce 6 🗆 Ott	ner (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF (Month, De		b. TIME OF INJURY		RK?		EŞCRIBE HOW II	JURY OCCUP	RED	
B	2 Accident Investigation " 1 YES 2 NO										
8	3 Suicide 8 Could not be 4 Homicide determined	building,	atc. (Specify)	rarm, street, fa	ctory, offic	•	28f. LC	y or Town, State)	nd Number or	Rural Route	e Number,
E	29a. CERTIFIER									_	
OMPL	(Check only one) 2 MEDICAL EXAMINER		my knowledge, death o								
0	296. SIGNATURE AND TITLE OF CERTIFIER	Desire of Ex			ориноп, с			te and place, an			
BE	R Sewar File	w				29c. LICENSE				16/9.	onth, Day, Year)
2	30 NAME AND ADDRESS OF DEDSON WIND	COMPLETED CALL	E OF DEATH ATEM AT	(T D/-1)		038	622		10	116/7.	7

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

R. STEWART FINNEY, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204

31. DATE FILED (Month, Day, Vent)

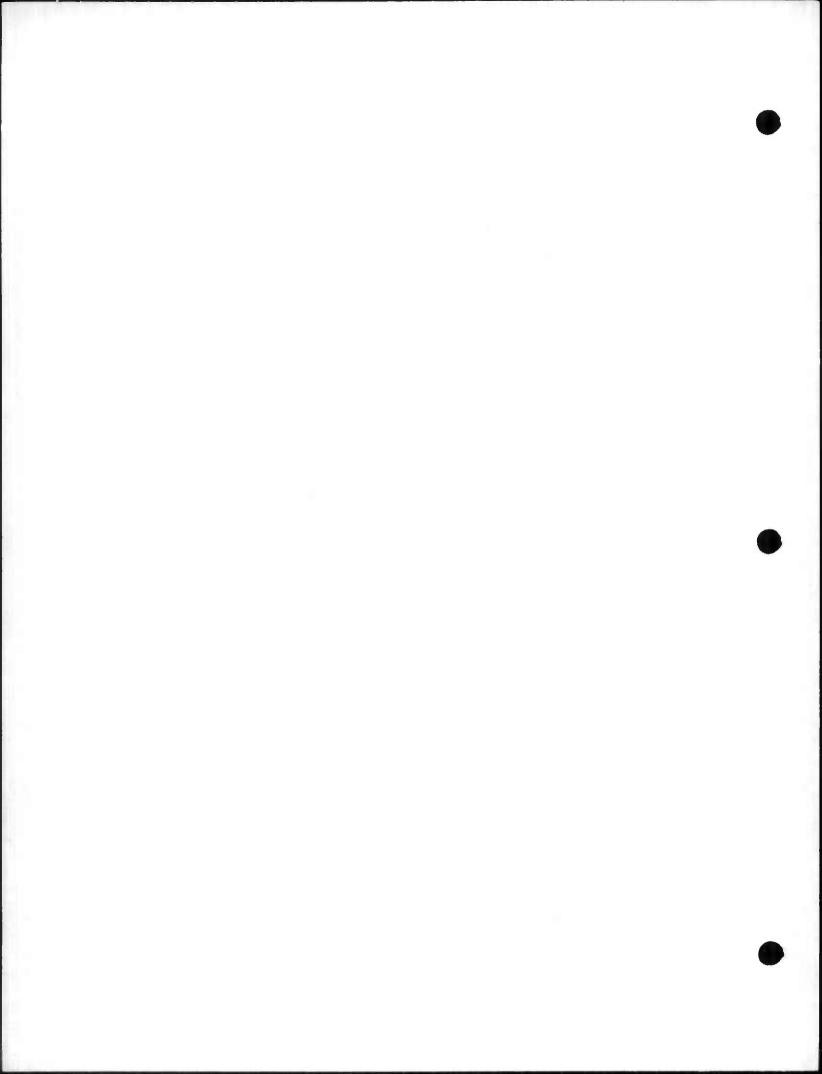
OCT 1 8 1995

Julia Dissipation founds.

DHMH-16 Rev 1/89

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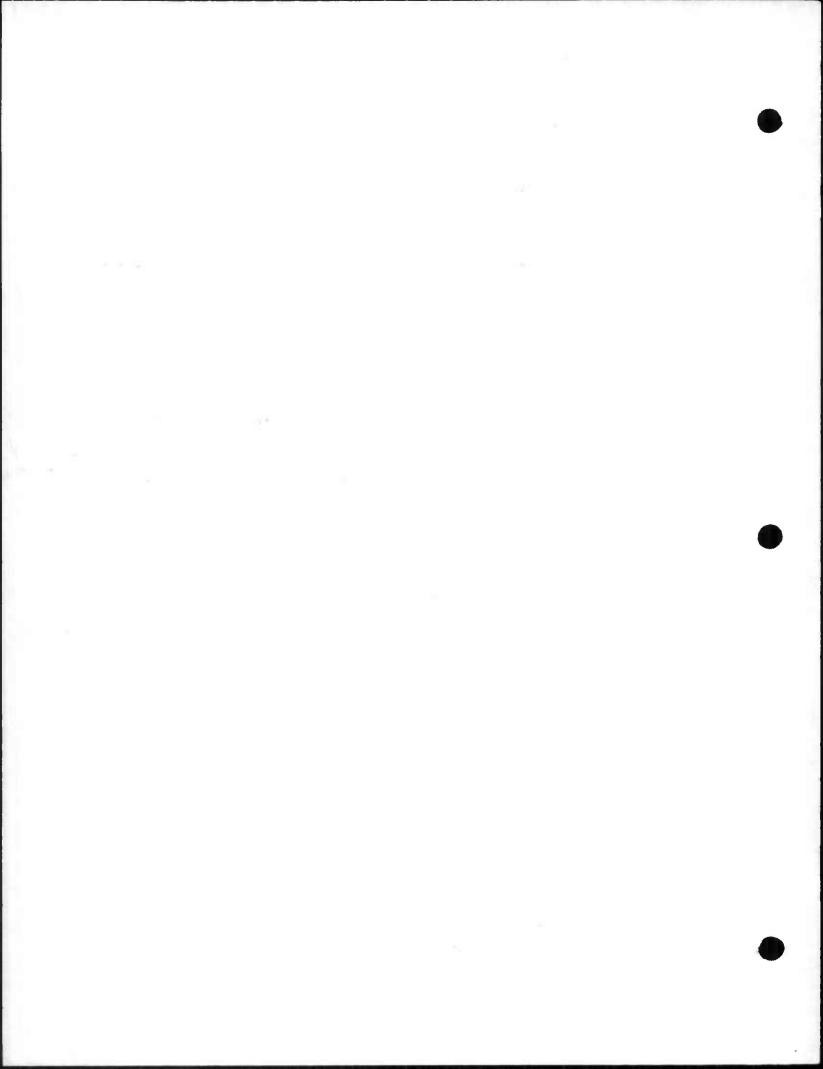
	1. DECEDENT'S NAME (First, Middle, Les	-01			CATE O		REG				
	Mary C.						2. DATE OF DEATMONTH	1995	YEAR	3. TIME OF DEATN	
	4. SOCIAL SECURITY NUMBER	1	6. AGE (In yrs. lesi		F UNDER 1 YEAR		3 DATE OF BURE		a. BIRTN	8:45 A	
	579-32-5445 9a. FACILITY NAME (If not institution, giv	1 🗆 M 2 💢	88	YRS.	ONTHS DAY		(Month, Day, Ye		_	shington I	
FOR	Villa Rosa Hom			9		N OR LOCATION OF D Dellville	EATN		cince	George's	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUR			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY	
		nce George	's	В	owie					1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 12700 Chesney I	ane				20715	United			States	
BY	t1. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAI	YES 2 N		If yes,	ECENDENT OF NISPA specify Cuban, Mexic ES 2 NO Specif	an, Puerto Rican, ate	y Yea or No—	14. RACE Black Speci	,	
TED	15. DECEDENT'S EI (Specify only highest gra		eted) (Give kind of work do				16b. KIND O	BUSINESS/IN	ce		
PLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)			,			**			
COMPL	17. FATHER'S NAME (First, Middle, Last)		I_RO	memak	er	16. MOTNER'S NA	AME (First, Middle, M	Home			
BE (Timothy J. Cos	tello				Margar	et M. Fl	aherty	7		
2	190. INFORMANT'S NAME (Type/Print)					et and Number or Rural					
	Joann Y. O'Conn	or (Cousin		2700 (Chesne	v Lane, F McCt 11,1	Bowie, Maryland 20715				
	**************************************	emoval from State			arron C	motorz		ilmox	Conin	oor Manasi	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EVEN From Conditions that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,										
	anock, of heart failure	or complications that ce. List only one cause	caused the date on each lina.	ath. Do not	Old	and address of fa Alexandri	icilitee Fu .a Ferry	neral Road,	Home, Clint	Inc 6633 ton, Md 20	
	23. PART I. Enter the displaces, o shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. List brily bre cause	caused the dage on each line.	ua,	Old	and address of fa Alexandri	icilitee Fu .a Ferry	neral Road,	Home, Clint	Inc 6633 ton, Md 20°	
ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. DUE TO (C	e on each line.	UENCE OF):	Old	AND ADDRESS OF FA	icilitee Fu .a Ferry	neral Road,	Home, Clint	Inc 6633 ton, Md 20	
RTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a. DUE TO (O	OR AS A CONSEC	UENCE OF):	Old	AND ADDRESS OF FA	icilitee Fu .a Ferry	neral Road,	Home, Clint	Inc 6633 ton, Md 207	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a	OR AS A CONSEQUENCE OF AS	UENCE OF):	22. NAME Old anter the r	AND ADDRESS OF FA Alexandri mode of dying, such	a Ferry	neral Road,	Home, Clint	ton, Md 20' Approximate interval Betwonset and Di	
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions of August 100 and 1	a. DUE TO (O	OR AS A CONSECUTION OF AS	UENCE OF): UENCE OF): Desulting in	22. NAME Old anter the r Bill	Alexandri node of dying, such alexal	Part I. 24a. WA	neral Road,	Home, Clint rrest,	The 6633 ton, Md 20' Approximate interval Betwoes and De 8 Days WERE AUTOPSY FINDIN AMAILABLE PRIOR TO	
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algoriticant conditions of August 1. Other algorithms of August 1. Other algor	a. DUE TO (O b. DUE TO (O c. DUE TO (O d. DIRECTO TO TRIBUTE TO CAU	OR AS A CONSEQUENT OF THE PROPERTY OF THE PROP	UENCE OF): UENCE OF): UENCE OF): UENCE OF): UENCE OF):	the underly	Alexandri node of dying, such alexal	Part I. 24a. WA	neral Road, espiratory a	Home, Clint rrest,	Approximate interval Betwonset and De B DayS	
SICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algorificant conditions of the condition o	a. DUE TO (O b. DUE TO (O c. DUE TO (O d. DIR CONTRIBUTE TO CAU HOSPITAL: I Inpatient 2 E 28a. DATE OF IN	DR AS A CONSEQUENT OF AS A CONSE	UENCE OF): UENCE OF): UENCE OF): UENCE OF): OBUILTING IN TH YES E OF DEATN Q 28b. TIME C	the underly the underly Check only on The R: NO Check only on The R: Nursing No	AND ADDRESS OF FA Alexandri node of dying, such alexal Ing cause given in UNCERTAIL One 5 Residence	Part I. 24a. WA	neral Road, espiratory a	Home, Clint rrest,	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSOF DEATH?	
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TED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the condition of the condition of the condition of the cause of the condition of the	a. DUE TO (O b. DUE TO (O c. DUE TO (O d. DIE TO CO ITRIBUTE TO CAU HOSPITAL:	OR AS A CONSEQUENT OF DEAT OF	UENCE OF): UENCE OF): UENCE OF): UENCE OF): OBUITING IN UENCE OF): OBUITING IN OBUITING I	the underly NO (Check only on True Fr: Nursing No M	AND ADDRESS OF FA Alexandri node of dying, such alexal Ing cause given in UNCERTAIL UNCERTAIL One 5 Residence VORK? YES 2 NO	Part I. 24a. WAR	S AN AUTOPSY PRORMED? S 2 NO	Home, Clint rest, 24b.	Approximate Interval Betwonset and De B Day's WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLET PRIOR TO COMPLET PRIOR TO FEATH? 1 YES 2 NO	
MPLETED BY	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are under the condition of the condi	a. DUE TO (O b. DUE TO (O c. DUE TO (O d. DIE TO CAU TRIBUTE TO CAU HOSPITAL: 1 Inputent 2 E 28a. DATE OF IN (Month, Day, 10 28b. PLACE OF Is building, at	PARA A CONSEQUENT OF AS A CONSEQ	UENCE OF): UENCE	the underly The set of the set o	AND ADDRESS OF FA Alexandri node of dying, such alexal Ing cause given in UNCERTAIL One 5 Rasidence NJURY AT WORK? YES 2 NO Itea	Part I. 24a. WAR PET I VE PET	S AN AUTOPSY PRORMED? S 2 NO DW INJURY OC Treet and Number hate)	Home, Clint rrest, 24b.	Approximate interval Between Onset and De 8 Days WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 No	
ETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are under the condition of the condi	a. DUE TO (O b. DUE TO (O c. DUE TO (O d. DIE TO CAU HOSPITAL: Impatient 2 = 28a. DATE OF IN (Month, Day, or building, at the seals of example)	PARA A CONSEQUENT OF AS A CONSEQ	UENCE OF): UENCE	the underly The set of the set o	AND ADDRESS OF FA Alexandri node of dying, such alexal Ing cause given in UNCERTAIL One 5 Rasidence NJURY AT WORK? YES 2 NO Itea	Part I. 24a. WAPEI 1 YE SCHOOL OF YOUR SERVICE	neral Road, espiratory a spiratory	Home, Clint rrest, 24b, 24b, 24b, 24b, 24b, 24b, 24b, 24b	WERE AUTOPSY FINDINAMILABLE PRIOR TO COMPLETION OF DEATH?	



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		REGISTRAR				CER	III	ICATE	OF	DEAT	H		REG. NO											
		1. DECEDENT'S NAME (First, Mid		D								MONT	OF DEATH	iA.	/FAR	TIME OF DEATH								
,		Harold 4. SOCIAL SECURITY NUMBER		Russell						,			ber 14			7:45PM M								
			- 1	5. SEX		In yrs. leat birt		IF UNDER	1 YEAR DAYS	HOURS	24 HRS. MIN.	(Mon	OF BIRTH th, Day, Year)		Country)	ACE (State or Foreign								
pio		579-22-8614			6	9 '	RS.						y 21,			ington,DC								
3 should	m	Se. FACILITY NAME (If not institut								OR LOCATION		ATH		9c. COUNT	Y OF DEA	ТН								
2,	ᅙ	3504 Springda		e.				For	estv	ville				Princ	e Ge	orge's								
Pages 1	l m		. COUNTY			10	c. CIT	Y, TOWN C	R LOCAT	ION					10	d. INSIDE CITY								
	DIRECTOR	Maryland P	rince	George	's	1 7	or	estv	ille	,					1 YES 2 X NO									
permit.	4	10e. STREET AND NUMBER						0.00	_	. ZIP CODI				10g. CITIZE		T COUNTRY?								
蓝	FUNERAL	3504 Springda	le Av	e.						2	0747				S.A.									
physician. burial-transit	3	11. MARITAL STATUS	1	2. WAS DECEDER			S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No - 14. RA						. RACE -	American Indian,										
phy pur	BY F	1 Never Married 2 Mer		FORCES?																				
attending physician se as the burial-trar					946		Specify: White Specify: White						9											
use a	ETED	15. DECEDEI (Specify only high	NT'S EDUCAT hest grade con			(Give ki	nd of u	vork done o	CUPATIO	ON st of working	g													
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by the		17. FATHER'S NAME (First, Middle, Lest) HOMEY RUSSEll																						
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2 2	임	Louise Russe											ber, City or Tow			7.47								
may be or, page		20a. METHOD OF DISPOSITION	<u></u>		20h	PLACE AND I					ve.,	FOL	estvil	LE, M										
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y filled in tion, or re		iMMEDIATE CAUSE (Finel disease or condition		101	1.1	11/20		01:		, .	1.	-				Onset and Death								
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	1 - STATE REGISTRAR	STATE OF MARYLANI	CERTIFICATE	OF DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Le	Boy/ Right	y Michael Antl	hony Rivers,	2. DATE OF DEATH DAY	9'S 1150 A
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs	YRS. IF UNDER 1	VEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTIN (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
CTOR	On FACILITY NAME (Il not institution gi	the street and number),	9b. CITY, T	OWN OR LOCATION OF D		COUNTY OF DEATH
DIRECT	10a. STATE 10b. COU	N//A	10c, CITY, TOWN OR	LOCATION	T.	16d. INSIDE CITY LIMITS? 1 PES 2 NO
ERAL	100. STREET AND NUMBER 1904 WALK	brook Ave	7677	101. ZIP CODE 2/2/1	7	9. CITIZEN OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Prever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES	ZAD H	AS DECENDENT OF NISPA yea, specify Cuban, Maxic YES 2 70 Speci		14. RACE — American Indian, Black, White, atc.
ETED	15. DECEDENT'S I (Specify only highest g. Elementary/Secondary (0-12)		(Give kind of work done du ilfe. Do NOT use retired.)	CUPATION ring most of working	18b. KIND OF BUSINES	SS/INDUSTRY
COMP	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Melder Sum	nois
TO BE	Mr. M. Ch. A.C.	Rivers	196 MAILING ADDRESS	Street and Number or Rural	Route Number, City or Town, St.	
	20a METNOD OF DISPOSITION 1 Burial 2 Cremation 3 F 4 Donation 8 Other (Specify)	samoval from Stata Coapeter	crematory or other place)	em	PAYE 20c. LOCATI	ON - City or Town, State,
	21, SIGNATURE OF FUNERAL SERVICE	2. Russ	22 N	AME AND ADDRESS OF F	ELES FUNC	ral Home
	22 Hotel & Enter the diseases		Be	792W,N	orin Hue, 1.	24/10/10/212
	shock, or heart failu IMMEDIATE CAUSE (Finsi disease or condition	or complications that caused the	line.	0	,	Interval Between
Z	shock, or heart fallu IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	or complications that caused the	Ilne. Lene NSEOUENCE OF):	Prema	,	Interval Between
ICATION	shock, or heart failu IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. DUE TO (OR AS A CO	Ine. Feme NSEOUENCE OF): A TO 12 L NSEOUENCE OF): O XICO	0	,	Interval Between
ERTIF	shock, or heart fallu IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	or complications that caused the re. List only one cause on each a. DUE TO (OR AS A CO	Ilne. Lene NSEOUENCE OF):	Prema ongs	,	Interval Betwee
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SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

ON MD 22

Day, Year)

18 1995

1995

Day, Year)

And Call

30. NAME AND AU.

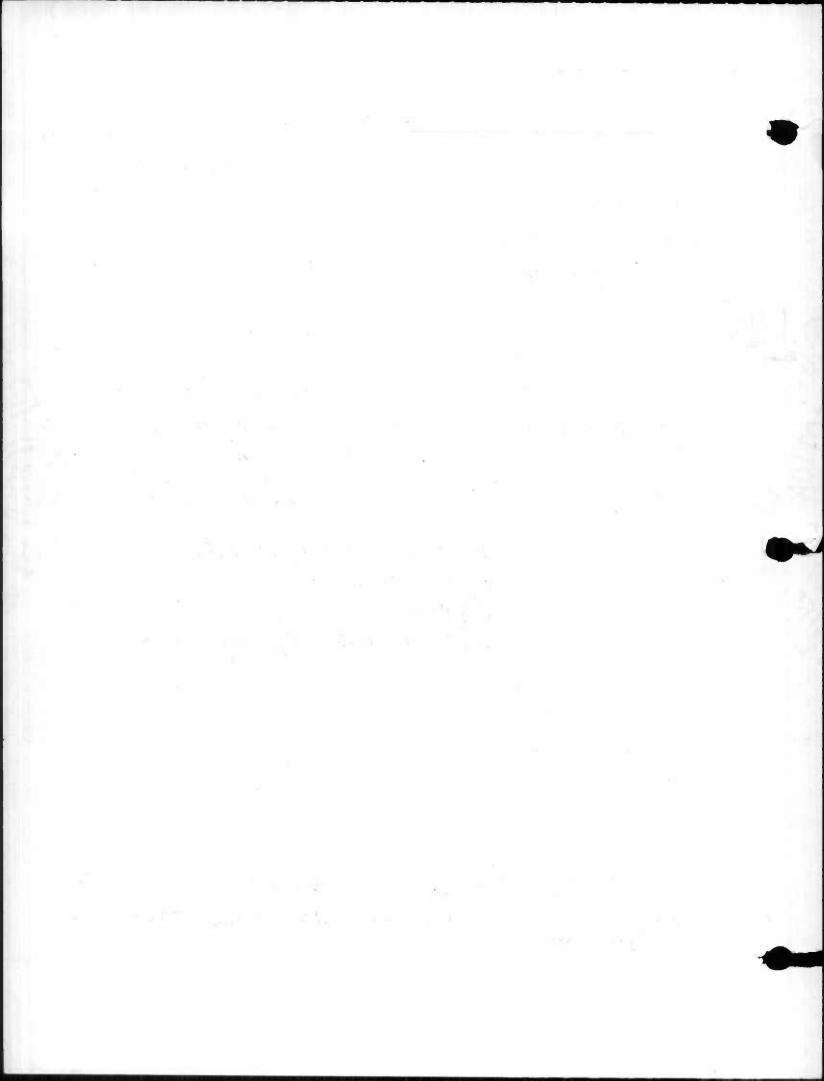
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31. DATE FILED (Month, Day, Year)

OCT 18 1995

21201

Greene Street

South



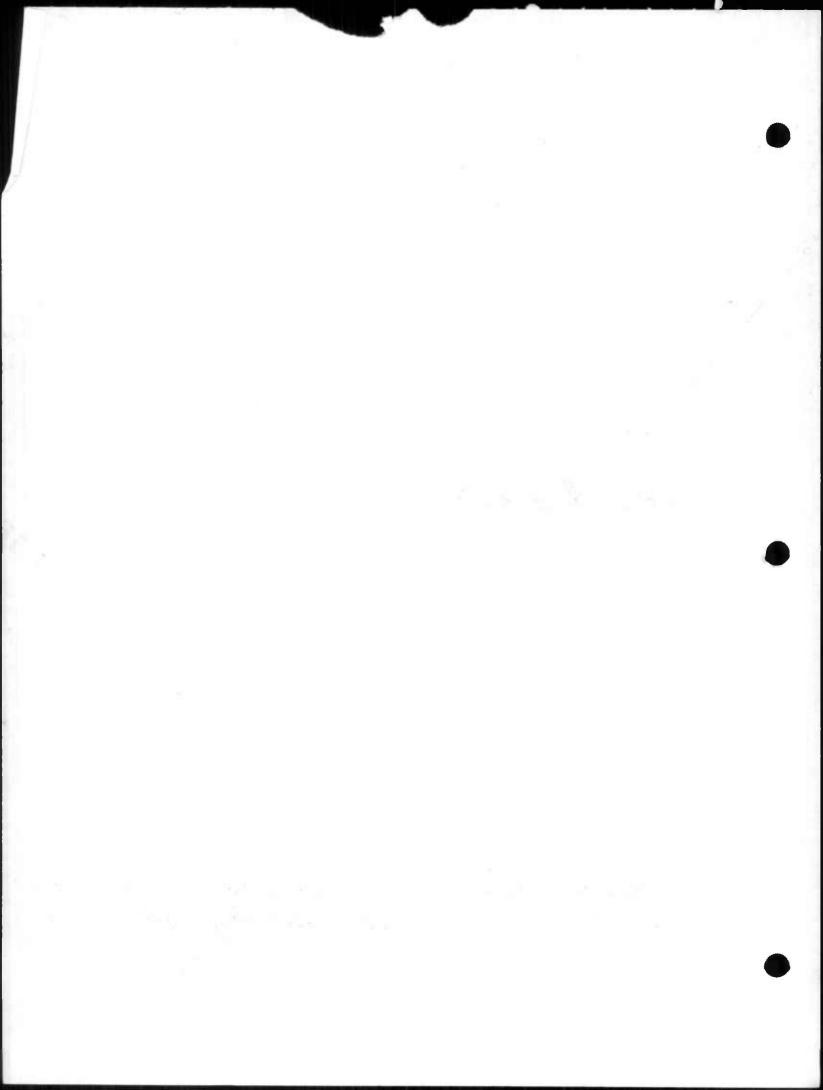
y the hospital or attending physician.	e detached for use as the burial-transit permit. Pages 1, 2, 3 should		rt once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 st	be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to bunal, cremation, or removal.	PPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

2. DETECTION OF DEATH OF

	t. DECEDENT'S NAME (First	Micidia Last)			OLITTI	IOAII		DEA		2. DATE OF DEATH			3. TIME OF DEATH		
		Carelli -								MONTH D	AY 1	YEAR			
	Eleanor		EV 5, SEX	A AGE //-	s. lest birthday)	IF UNDER	0.4 9545	IF UNDER		October 1	3, 1		11:00 P. M		
	A STATE OF THE STA	ER	100		s. real pirtnday) VRS.	MONTHS	DAYS		MIN.	(Month, Day, Year)		Countr	γ)		
	216-74-7001		1 🗆 M 2 💢 F	71	rna.		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE						/land		
~	9a. FACILITY NAME (If not in														
DIRECTOR	Forest Have	Nurs:	ing Home			Car	ton	sville	e		Ba	ltimo	ore		
2	10s. STATE	10b. COUNTY			10c, CI	ITY, TOWN OR LOCATION						10d. INSIDE CITY			
E	Maryland	Balt	imore		1						LIMITS?				
	toe STREET AND NUMBER	Dure.	INOIC		Tate	Catonsville 10f. ZIP CODE									
FUNERAL	315 Ingles:	ide Atr						21228			200		OF WHAT COUNTRY?		
N.	tt. MARITAL STATUS	tue Ave	t2. WAS DECEDEN	17 F1/F0 IN 11 6											
	1 Never Married 2	Married	FORCES? 1	YES 2	2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.) B					Black	— American Indian, c, White, atc.				
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES						1 🔲 Y	ES 2X NO	Specifi	y:		Speci	White		
	15. DECEDENT'S EDUCATION 18e. DECEDEN						CCUPA	TION		16b. KIND OF BU	SINESS/IN	OUSTRY			
	(Specify only highest grade completed) (Give kind					work done use retired.)	during i	most of worki	ng	TOD. KIND OF BO	3114633/114	DOSTRI			
7	Elementary/Secondary (0-12) College (1-4 or 5+)						5c				N/A				
COMPLETED	0 Neve:					MOTVE	su	16 MOT	HEB'S NA	ME (First, Middle, Maiden					
	James Riley														
BE	19a. INFORMANT'S NAME (100 14411111	C ADDRES	0 (0000			ette Giere Route Number, City or Tov		(- O-d-)			
2												p Code)	181		
	Daniel R. F								TCIM	ore, Md. 2		A 11			
	1 1 Burial 2 Crematic	n 3 🗆 Rem	oval from State		ACE AND DATE OF THE CONTROL OF THE C							City or To			
	4 ☐ Donation 6 ☐ Other 21. SIGNATURE OF FUNERA		NEW DEF	WOO	atawn						Ttim	ore,	Maryland		
	21. SIGNALIME OF FUNERA	L SERVICIO	ENSEE	M				AND ADDRE		r Funeral	Uomo				
	Alman	-l	1.12	12/14	-					Ave. Bal		no l	18. 21229		
	23. PART I. Enter the d	iseasea, of	omplications the	1 caused th	e death. Do	not enter	r the n	node of dy	ing, auc	h as cardiec or resp	Iratory a	rreat,	Approximate		
			List only one ce	uae on eech	line.		,						Interval Between Onset and Death		
1	IMMEDIATE CAUSE (Figure 1) disease or condition	101	Const	mal	Than	2 22 -	La	5					10/3/90		
ŀ	reaulting in death)			OR AS A CO				16					15/95		
-															
Ó	Sequentially list condit		DUE TO	OR AS A CO	NSEQUENCE (DF):									
Ā	If any, leading to imme cause. Enter UNDERLY	ING													
CERTIFICATION	CAUSE (Disease or Injuthet Initieted events	ity	c. DUE TO	OR AS A CO	NSEOUENCE (OF):									
E	resulting in death) LAS	т													
E			d												
	PART II. Other significa	nt condition	a contributing to	deeth but	not reaulting	In the u	nderly	ing ceuee	given In	Part I. 24s. WAS AP		24b	WERE AUTOPSY FINDINGS		
EDICAL										1 YES	-		COMPLETION OF CAUSE OF DEATH?		
													t YES 2 NO		
Σ.	DID TOBACCO L	ISE CONT	RIBUTE TO CA	AUSE OF I	DEATH Y	ES 🖂	NO	☐ UNG	CERTAI	NB					
PHYSICIAN:	25. WAS CASE REFERRED 1				PLACE OF DE										
200	EXAMINER?	-/11-2	HOSPITAL:	ER/Outputle	et 3 🗆 DOA	OTHE	B		- ald- aa-	6 C Ottob (Consts)					
¥	27. MANNER OF DEATH		28e. DATE O	-	28b. TI	ME OF	_	INJURY AT	WEIGHTCH	6 ☐ Other (Specify) 28d. DESCRIBE HOW	INJURY O	CCURED			
	. /	Pending		Day Year)	10	IJURY M	1	WORK?	NO	200. 02001102 (1011		3001122			
В	2 Accident	Investigation	28a. PLACE	OF INJURY —	At home form	etrant fac				281, LOCATION (Street	and Numb	er or Russi i	Doude Number		
ED	3 Suicide 6 4 Homicide	Could not be determined	building	, atc. (Specify)	ris rigiting, marrie	arroat, iac	olory, o			City or Town, State		or or norar r	Number,		
回	and DESCRIPTION	1		-						<u> </u>	_				
릴	one)									to the cause(s) and me					
COMPLET	one) 2 MED	ICAL EXAMINE	R: On the basis of	examination en	id/or Investigat	lon, In my	opinion	i, death occu	red at the	time, data and place, a	nd due to	the cause(s) and menner as stated.		
0	296. SIGNATURE AND TITLE	OF CERTIFIE	21/	7	no no			29c. LIC	ENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)		
00	Maris	LO	206	1				101	58	72	11/	10x	16 1995		
임	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAL	JSE OF DEATH	(ITEM 27) (Typ	e, Print)		1		-/ /	1	1			
	HORRELD B. BUBMO THE SAR GENELL THE 21201														
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE														
	OCT 1 8 1995 July Studen Real At														
		()													



REG. NO.

detached for use as the burial-transit permit, Pages 1, 2, 3 should

completely filled in by the

cremation.

prior to burial,

signed by the attending physician Health and Mental Hygiene prior to

been of t

this certificate has be with the State Dept.

DIRECTOR: After the hours after death

FUNERAL I

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FOR STATE REGISTRAR

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DIVISION OF VI	E
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 1995 8:38 P David Alan Remphrey October 15 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Ybar)
NOV. 13, 1947 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 - F 203-36-4856 Pennsylvania Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2060 Jasmine Road Dundalk Baltimore DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE 21222 United States 2060 Jasmine Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 Y YES 2 □ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, stc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 YES 2 X NO Specify: Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) 12 Years Carpenter Construction Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) To Harold Remphrey Betty Cotterman notified : 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara L. Remphrey 2060 Jasmine Road Dundalk, Maryland 21222 9 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Gardens of other p Faith Maus. 10/18/95 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 medical PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the static disease or condition 9 monit Neta event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL any negopores 1 TES 2 No OF DEATH? shows a 1 - YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 28. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home Senidance 8 Other (Specify) 00 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED is marked, 1 Natural INJURY 5 Pending М 1 YES 2 NO BY 2 Accident investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 28 4 Homicide tem 29s. CERTIFIER

//Chack nnh

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IT 2 MEDICAL EXAMINER: On the besis of a 29c. LICENSE NUMBER BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 PROBLEM REAL PROPERTY.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR		STATE OF I			TMENT O				MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
Theresa A	Ravs	inger							October 1	5, 1	995	9:00 A. M
4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs	last birthday)	IF UNDER 1 YE	EAR	IF UNDER 2	4 HRS.	7. DATE OF BIRTH	-/-	8. BIRTH	IPLACE (State or Foreign
215-01-1689		t 🗆 M 2💢 F	99	YRS.	MONTHS DA	NYS.	HOURS	MIN.	(Month, Day, Year) 9/9/1896		Moza	yland
9a. FACILITY NAME (If not in	nstitution, give s	treet and number)	99		9b. CITY, TO	WN O	R LOCATIO	N OF DE		9c. COL	INTY OF O	
Meridian Nu	rsing .	Home - C	atonsvi	тте	Cat	ons	svill	<u>e</u>		Ba	ltim	ore
10a. STATE	10b. COUNTY	Y		10c. CIT	Y, TOWN OR L	OCATI	ON			-		10d. INSIDE CITY
Maryland	Balt	imore		Ca	tonsvi	11ϵ	9					LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER						101.	ZIP CODE			10g. CIT	IZEN OF Y	WHAT COUNTRY?
16 Fusting	7/470					21	1228			USA		
11. MARITAL STATUS	Ave.	12. WAS DECEDEN	IT EVER IN U.S.	ARMED	13. WAS			HISPAN	VIC ORIGIN? (Specify Yes		Y	E — American Indian,
t 💟 Never Married 2 🗌	Married		YES 27		If yo	s, spe	city Cuban.	, Mexica	n, Puerto Rican, etc.)		Blac	k, White, etc.
3 Widowed 4 Div	orced	IF YES, GIVE Y	WAR OH DATES			YES	2X NO	Specify	γ.		Spec	"White
15. DEC	CEDENT'S EDU	CATION	16a		USUAL OCCU				16b, KIND OF BU	SINESS/IN	DUSTRY	
(Specify on Elementary/Secondary (ly highest grade			(Give kind of life. Do NOT u	work done during se retired.)	ng mos	t of working	1				
12th	0-12)	College (1-4 or 5		erk-	Clerk	(Life In	cura	nce	
17. FATHER'S NAME (First, A	Aicidle, Last)			SEN.			16 MOTH	FR'S NA	ME (First, Middle, Maiden		rice	
Joseph Ra		~					_		Ereans	Ourname)		
19a. INFORMANT'S NAME (T.		401 1441 144	100000000000000000000000000000000000000					0		
	.,								Route Number, City or Tow			21237
Dorothy Mar								l. A	pt. 101 Ba			
1 X Burlai 2 Cremati	on 3 🗆 Rem	oval from State	cemetery	crematory or o	OF DISPOSITION (No. 1)	,					- City or To	
4 ☐ Donation 6 ☐ Othe			New	Cathe	dral C					alti	more	, Maryland
21. SIGNATURE OF FUNERA	AL SERVICE-DIC	CENSIGE	./				D ADDRES		r Funeral	Home		
CAR	-1	4/1/	Mus	-)					n Ave. Bal			VIA 21220
23. PART I. Enter the	ilseases of	complications the	ot caused the	death. Do								Approximate
ahock, or h	neart fellure.	List only one car	use on eech	line.			ac or cryst	.g. ouc	it so cordisc or resp	watery an	rear,	interval Between
iMMEDIATE CAUSE (FI disease or condition	nai	A		14 /				T	4			Onset and Death
resulting In death)	\rightarrow	· ACL	TE	MYO	CARD	MA		LNF	5min.			
		DUE TO	(OR AS A CON	ISEQUENCE O	F): / (7	EARCTION SEASE			
Sequentisily list condi	tions.	b. C.C	RON	ARY	HEA	1/2_	T	11.	SEASIS			
If sny, leading to imme	ediate	DUE 10	(OR AS A COM	ISEOUPNCE O	F):							
cause. Enter UNDERLY CAUSE (Disease or Inj.		c										
that initiated events resulting in death) LAS	eT.	DUE 10	(OR AS A CON	ISEOUENCE O	F):							
resoluing in destity Exc		d										
PART II. Other aignific	ant condition	ne contributing to	deeth but n	ot resulting	in the under	rivino	ceuse d	lven in	Part I. 24s, WAS AN	AUTOPSY	240	. WERE AUTOPSY FINDINGS
Severe		REBROU					C . 2		PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
					0-	14/	-1	Zj.	1 _ YES :	NO		OF DEATH?
		Multi-1			JEME	70	THA					t TYES 2 NO
DID TOBACCO (RIBUTE TO CA				X	ÚNCI	ERTAI	иЦ			
25. WAS CASE REFERRED ' EXAMINER?	TO MEDICAL	HOSPITAL:	26. F	PLACE OF OEA	OTHER:	one)						
t TYES 2 NO		t 🗆 Inpetient 2	ER/Outpatian	R 3 DOA		Home	5 🗆 Rat	sidence	6 Other (Specify)			
27. MANNER OF OEATH		26a. DATE OI (Month, I	F INJURY Day, Year)	26b. TIR	JURY 26	c. INJU WOI	JRY AT		28d. OESCRIBE HOW	INJURY O	CCURED	
1 Natural 5 2 Accident	Pending Investigation				M	t 🗌 ¥	'ES 2 🗌	NO				
3 Suicide 6	Could not be		OF INJURY - A	At home, term, street, factory, office			261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
4 Homicide determined						Say or rown, State	, State)					
29a. CERTIFIER	TIFYING PHYS	ICIAN: To the best of	f my knowledos	death occur	red at the time	date	and place	and due	to the cause(a) and ma	mer ee et	ated.	
TOTIOCA CITY												a) and manner as stated,
PON SIGNATURE AND TITL					-	, ,		MCE MIN		1		

CHIRAN 720 MAIDEN CHOICE

32 PENSTAINS SIGNATURE SUNATURE SUNATURES

MACHIRAN

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 212

permit. Pages 1, 2, 3 should

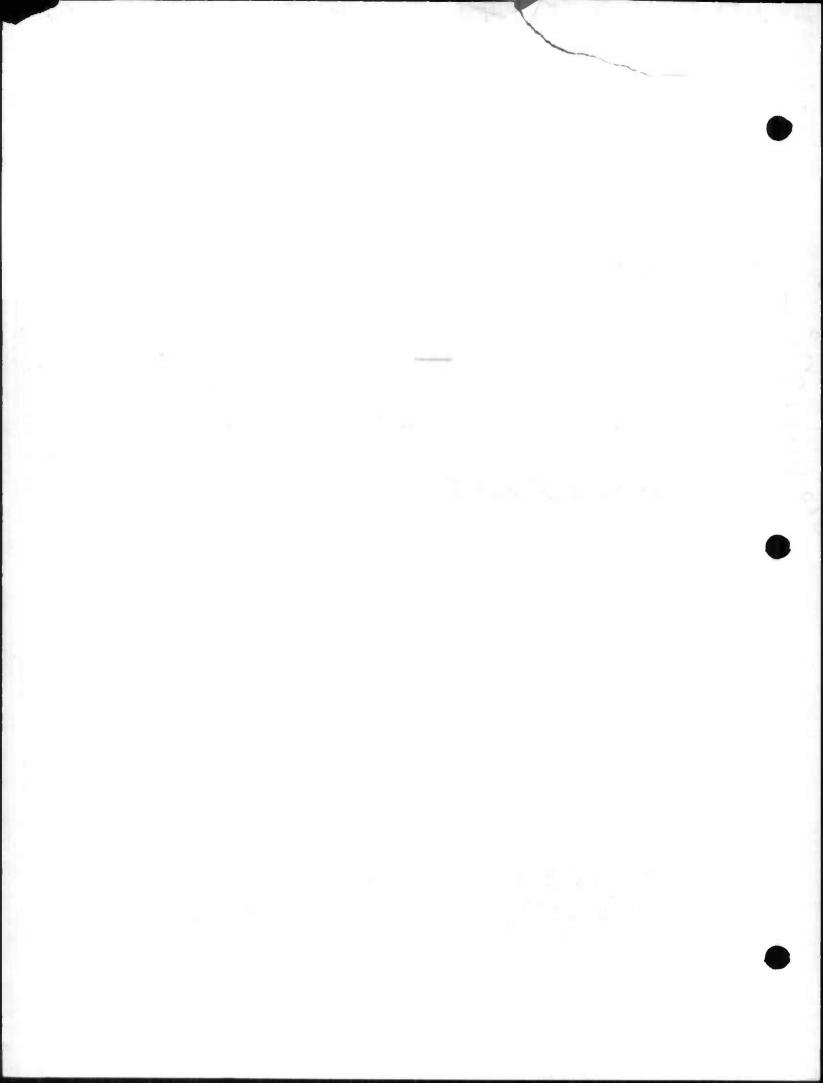
TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED MONTH D

10-16-95



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

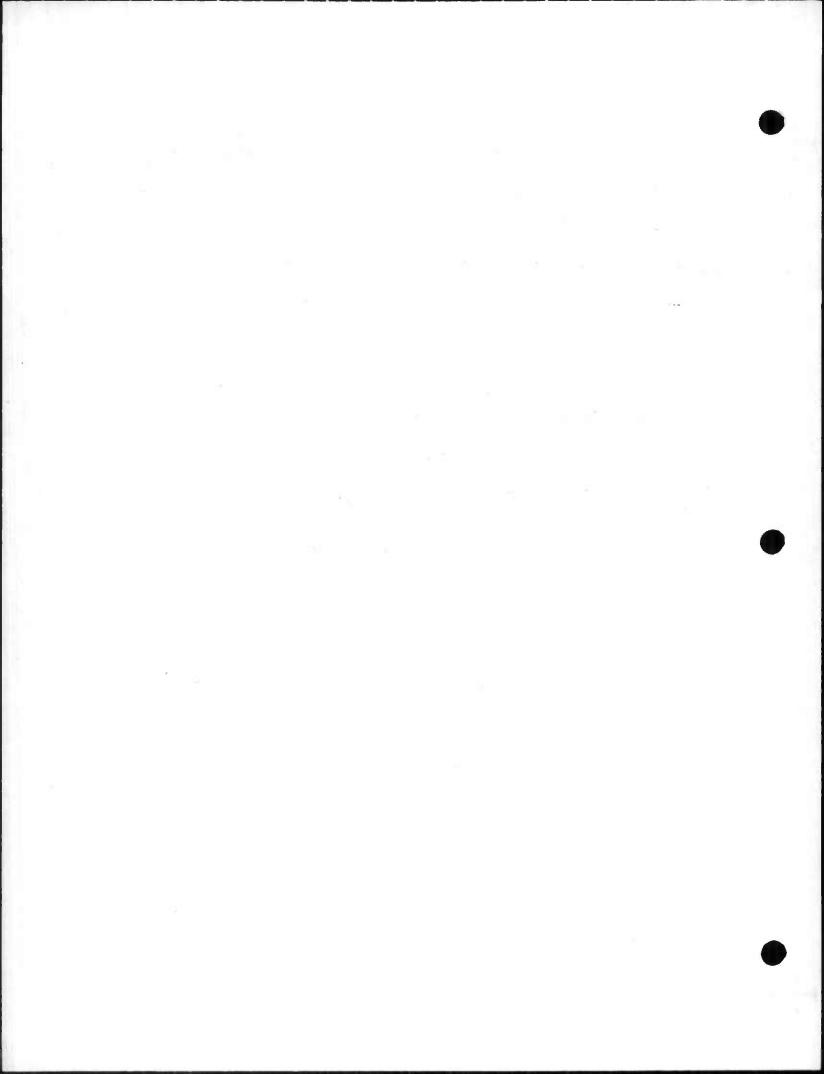
	FOR 1 - STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.				
	t. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF OEATH		
1	WILLIAM THO	MAS SMYTI	V		OCT 14	1995	7:30 AM		
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign		
	215-12-9502 90. FACILITY NAME (If not institution, give s	1 M 2 F	THE DAYS HOURS MIN.	SEPT 7 1921 MARYLAND					
DIRECTOR	DAK CREST VILL	4GE 8800 W		CARNEY	EATH	4	TMORE		
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	Υ	10c. CITY, TO	OWH OR LOCATION			10d, INSIDE CITY		
<u>۾</u> ا	MD. B	ALTIMORE		CARNEY			t YES 2 NO		
	10e. STREET AND NUMBER	TETTTOME		10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	8800 WAITHE	ER BLVD.		21	234	1)	SA		
3	11. MARITAL STATUS	12. WAS OECEDENT EVER I		13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yee o	e or No— 14. RACE — American Indian,			
	t Never Married 2 Married	FORCES? 1 X YES	2 NO ATES	If yes, specify Cuban, Mexico 1 ☐ YES 2 😿 NO Specifi		Black, White, etc. Specify:			
E E	3 Widowed 4 Divorced	WWI				WHITE			
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USI (Give kind of work	done during most of working	16b. KIND OF BUSIN	ESS/INDUSTRY			
<u>"</u>	Elementery/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use re		0-1-				
COMPLET	1 L YR5	4 yrs	ACCOU	NTANT		E- EMPLOYED			
8	17. FATHER'S NAME (First, Middle, Last)	a dama d		18. MOTHER'S N	AME (First, Middle, Meiden St.				
H	ALBERT SM	<i>YTH</i>		JAL	DIE SHIEL				
2	ton INFORMANT'S NAME (Type/Print)		1	DRESS (Street end Number or Rural	Route Number, City or Town,	State, Zip Code)	21030		
	200. METHOD OF DISPOSITION	4	113 V	VALNUIW DOD	RD. 4	DCKEYS	VILLE		
	to Buriel 2 Cremation 3 Rem		netery, crematory or other		10/	TION — City or 1			
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	ULANEY	22. NAME AND ADDRESS OF F		MONIUM	1		
		00			DEL OF CHI	MES			
۷	John Sm	class		2325 YORK	RD. TIMON	UUM	21093		
- 1	23. PART I Enter the diseasea, or shock, or heart feliure.	complications that cause Liat only one ceuse on a	d the death. Do not each line.	anter the mode of dying, au	ch as cardiac or respira	tory arreat,	Approximate Interval Between		
	IMMEDIATE CAUSE (Fine)	11.		1-00	4,00	- Just	Onset and Death		
	disease or condition reaulting in death)	a fly terio	ocher	Mix Cood	oursen	la-			
		DUE TO (OR AS	A CONSEQUENCE OF):						
2	Sequentially list conditions,	b.	ACAMPACITATION OF						
Ĕ	If any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE OF):						
드	CAUSE (Disease or Injury that initieted events	C. DUE TO (OR AS	A CONSEQUENCE OF):				-		
RTIFICATION	reaulting in death) LAST								
S		d							
4	PART il. Other algnificent condition	na contributing to deeth i	out not resulting in t	he underlying ceuse given in	Part I. 24s. WAS AN A		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
음ㅣ					1 _ YES 2 0	KNO	COMPLETION OF CAUSE OF DEATH?		
MEDIC							1 YES 2 NO		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE C		,	N 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEATH (Check only one) THER:					
PHYSICIAN:	1 ☐ YES 2 🙀 NO	1 Inpetient 2 ER/Out	petient 3 DOA 4	☐ Nursing Home 5 Reeldence	8 Other (Specify)				
H	27. MANNER OF DEATH 1 🔀 Netural 5 🗌 Pending	28a. DATE OF INJURY (Month, Day, Year)	286. TIME O	WORK?	28d. DEŞCRIBE HOW IN.	JURY OCCURED			
B	2 Accident Investigation	72.		M t YES 2 NO					
9	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spe	<pre>/ — At home, term, stre- cify)</pre>	et, factory, office	281. LOCATION (Street an City or Town, Stete)	d Number or Rural	Route Number,		
					l				
립				t the time, date end place, end du					
COMPLET	2 MEDICAL EXAMINI	ER: On the basis of axaminate	of end/or investigation, i	n my opinion, death occured at the	e time, date and place, end	due to the ceuse	(e) end menner es stated,		
BE	206. SIGNATURE AND TITLE OF CENTIFIE	"V		29c. LICENSE NU	IMBER	29d. DATE SIGNE	D (Month, Day, Year)		
	NITL	und		D169.	29	10	1(6195		
-	30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CAUSE OF DE			O1. A.	O DAN			
- 1	I K. C MH	111111111111111111111111111111111111111	11 21	12, Dund	NIK NO	salhi	MITTE		
	1, 2, 1,1,1	077 112							
	31. DATE FILED (MOST) 8795"	RECISTRARY BIG					TILL		

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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physician.	burial-transit	
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death. Page 6 m	ral direct	
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death ce	e attendin	Aental Hyp
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duires 1	n signed	f Health and I
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		1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF I			HYGIENI REG. NO.	Ε .				
V		1. DECEDENT'S NAME (First, Middle, Last)	S S = 5				2. DATE OF MONTH		Y Y	recom à	TIME OF DE	ATH	
		4. SOCIAL SECURITY NUMBER	DNA ST	in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	17	1995	\ \{\text{Sean} \ \{\text{Sean} \}	MCE (State or	PH	
Pin		113-24-1059	1 M 2 F	02 YRS.	MONTHS DAYS	HOURS MIN.	OCT ?	Down Manual	020	Country)			
2, 3 should	OR	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNT PARKVILLE BO									н		
—	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY,	TOWN OR LOCAL	TION				104	d. INSIDE CI	TY	
mit. Pag			LTIMORE		PARK					1[LIMITS?	NO	
physician. burial-transit permit. Pages	FUNERAL	3536 FIELD C	REEK WA	Y	10	ZIP CODE	34			SA	T COUNTRY?	*	
the sta	BY FUN	11. MARITAL STATUS 1 Never Married 2. Married 3 Widowed 4 Divorced	12. WAS OCCEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	I1 yes, ap	CENOENT OF HISPA ecity Cuben, Mexico 2 MO Specific	an, Puerto Ric		or No.— 14	Specify:		dian,	
attend se as	CE.	15. DECEOENT'S EQUO (Specify only highest grade	CATION comoleted)	16a. DECEDENT'S U	ISUAL OCCUPATIONS done during mo	ON post of prostring	16b, K	IND OF BUS	INESS/INDUS		HITE		
0 -	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	tress	se or working	A	meri	CAN	LEG	HOIL		
the hospital detached fo	CO	17. FATHER'S NAME (First, Middle, Last)	\			18. MOTHER'S NA		die, Maiden S	Surname)				
	BE	trederick HO 19a. INFORMANT'S NAME (Type/Print)	errington			EDNA		ARP	LES				
ay be retained page 5 should t be notified	2	GAIL Moone	У	3616		PPA Rd	Bal	to.	# 3	123L	1		
ector, par must b		20s. METHOO OF DISPOSITION 1	oval from State come	PLACE AND DATE OF	er place)	ame of	DATE	20c. LOC	calto,				
death. Page 6 m. s funeral director, J. examiner must		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1	22, NAME A	ND ADDRESS OF FA	CILITY						
		- Taket a	2 Joves	T	880	IS CHAP TO HARF	ORD	Kd. t	salto.	Md.	2127	34	
hours of rel		23. PART I. Enter the diseases, or c ahock, or haart fallura. I IMMEDIATE CAUSE (Final	omplications that ceused List only one cause on as	the death. Do no ich line.	of enter the mo	de of dying, suc	ch as cardis	c or respir	atory arrest	l,		mate Between nd Death	
nted within 24 completely fille ial, cremation, cevent, the		disease or condition resulting in death)	. Metasta	tic Su	nall	cell C	ng	Car	icer			nonet	
and comi burial, c	Z	disease or condition resulting in death) s. Metrostatic Small Cell lung Cancer 15 Month Due TO (OR AS A CONSEQUENCE OF): Sequentially list conditions,											
ate be executed ysician and con prior to burial, traumatic et	ATIO	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):	:								
Sertifica Sing ph ygiene other	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):									
0 0 0		PART II. Other significent conditions		44	45								
by In	JICAL	TANT II. OHIO SIGNICON CONDINON	contributing to deeth bu	it not reauting in	the underlying	g causa given in		PERFORI	MED?	AMA COS	RE AUTOPSY ILABLE PRIOR MPLETION OF	R TO	
requires that een signed b of Health ar shows any	MEDIC							_ /		17.5%	DEATH? YES 2	NO	
has be Dept.	PHYSICIAN:	DID TOBACCO USE CONTR		F DEATH YES	7	UNCERTAI	N 🗆	_					
IAN: The tificate he State C	SIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpa	5000 _ 30 C	OTHER:	e 5 Residence	8 Other (S	ipecify)					
PHYSICIAN: The law requires the this certificate has been signed with the State Dept, of Health inked, or Item 23 shows an		27. MANNER OF DEATH 1 Natural 5 Pending	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WO	RK?	28d. DESCR	IBE HOW IN	JURY OCCUR	ED			
After death	The state of the									Rural Route	Number,		
ATTEN RECTOR INS after	ETED	4 Homicide datarmined	building, etc. (Specia	fy)				lown, State)					
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 Is marked, or Item 23	COMPLET		CIAN: To the best of my knowle t: On the basis of examination							euse(s) sno	d menner ss	stated.	
HE HOS HE FUN ed with	w	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			29d, DATE SI		111317		
5 5 3 X	TO B	30. NAME AND ADDRESS OF PERSON WHO	t. 50,00	TH OTEN OF T		D26	0250		10	2/18	195		
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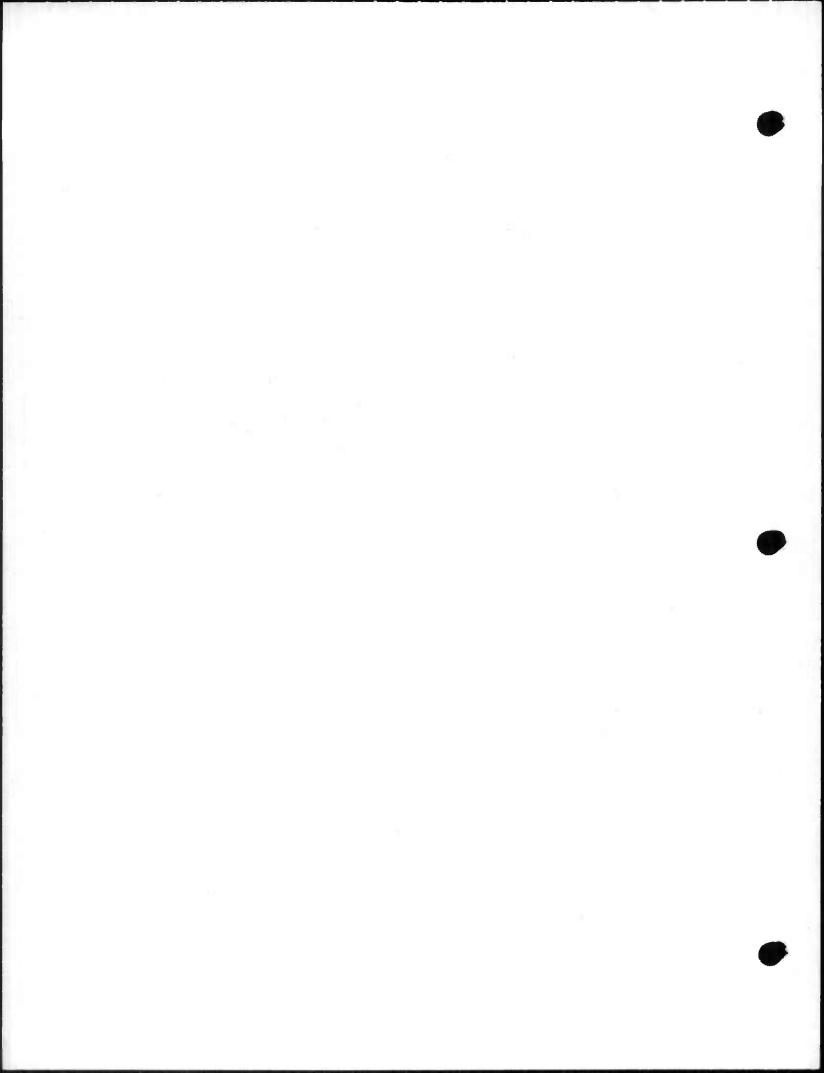
FOR STATE REGISTRAR 1 -TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within EX hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	Margaret K. Strai	ISS							OCTODE	PY T	7, 19	95	1:40 A
1	4. SOCIAL SECURITY NUMBER 214-18-1740	5. SEX	6. AGE (In yrs. 89	last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, D	BIRTH ny, Year)		Country	,
H	9a. FACILITY NAME (If not institution, give s North Arundel Hos				9b. CITY Gle	n Bu	PR LOCATI	ON OF DE	JAN.5	,1906	9c. COUNT	Y OF D	YLAND EATH NE ARUNDEL
DIMECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT			10c. CIT	Y, TOWN (10d. WSIDE CITY LIMITS?
- 1	MARYLAND A 100. STREET AND NUMBER	ANNE ARUNE	DEL		LIN	THI	ZIP CODE	E			10g. CITIZE	EN OF W	1 VES 2 NO
FUNEHAL	6219 GROVELAND RO						210	-				S.A	
3X Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify:						n, Puerlo Rica	ipecify Yea o n, etc.)	or No- 1	4. RACE Black Specif	- American Indian, , White, etc. y: WHITE			
COMPLEIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a.	DECEDENT'S (Give kind of v life. Do NOT us	vork done			ng	16b, KII	OF BUSH	NESS/INDU	STRY	
Ĕ	1	YR BUSINE	ESS	CLERI	CAL					H	UTZLE	R¹S	
2	17. FATHER'S NAME (First, Middle, Last) BARNEY BEALEFELD							HER'S NA	ME (First, Midd	lle, Malden St	umame)		
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a			Route Number,	City or Town,	State, Zip C	iode)	
-	MRS. JEAN LINS	-		6219	GROV	ELA	ND RC	AD -	- LINT	HICUM	, MD	21	090
	20s. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		20b. PLAC cemetery, LOUD	CE AND DATE OF OR OF OR PAR	K MA	USOI	LEUM		10/20		TIMOR		wn, Stata
	21. SIGNATURE OF PUNEDAL SERVICE LIC	* 1	Ele	12	HU	BBAH		JNER!	AL HOM: AVENUE			' M	D 21229
HILICALION	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
EDICAL CE	PART II. Other algnificant condition	a contributing to d	leath but no	ot resulting i	n the un	derlying	cause ç	given in		. WAS AN AL PERFORM	ED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Ε	DID TOBACCO USE CONTI	RIBUTE TO CAU	ISE OF DE	EATH YE	S 🔲 I	10 E	UNC	ERTAIN	v 🗆				1 YES 2 AND
TSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ACE OF DEAT	OTHER	₹:							
L	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED												
150 01	2 Accident Investigation M 1 YES 2 NO 3 Suicide 6 Could not be detarmined Detarmined						oute Number,						
COMPLEIEU	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE												and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	Link					29c. LICE	NSE NUN	18ER -9/	:	P OC	SIGNED .	(Month, Day, Year)
	30. NAME AND ABOTIESS OF PERSON WH SYED M. A. (31. DATE FILED (Month, Day, Year)	O COMPLETED CAUSE	800	N. He	Print)	no	rel	Fe	vy 1	Zef.	ant	trie	21090
	OCT 1 81995 &	le develor	12							· · · · · ·			



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

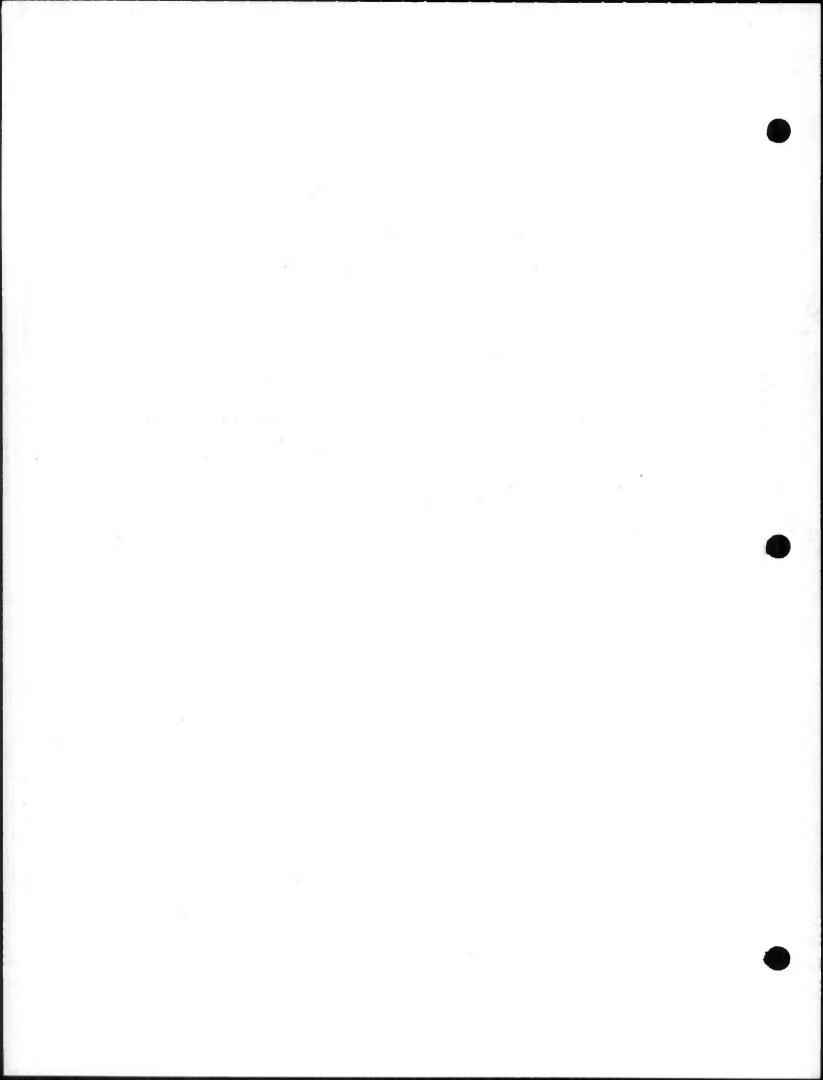
IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-6223-510

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

HEGISTRAH				EKIIF	ICALI	E OF	DEA	Н	RE	G. NO.				
1. DECEDENT'S NAME (Fin	st, Middle, Last)		STI	ERRET	гт				2. DATE OF DI MONTH OCT .	13	. 19	9°5°	3. TIME OF DEA 7:29	
4. SOCIAL SECURITY NUM	IBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BI	RTH			PLACE (State or	
219-10-59		1 🗆 M 2 🕵 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	1/11/	190		V . (Caroli	
9a. FACILITY NAME (If not institution, give street and number)					9b. CITY	Y, TOWN	OR LOCATI	ON OF DE	EATH		9c. COUR	ITY OF D	DEATH	
	2421 W. HARLEM AVE					BALTIMORE N/A								
10a STATE	10b. COUNTY	1			Y, TOWN								10d. INSIDE CIT	ſΥ
Maryland 104. STREET AND NUMBE	Maryland N/A 10. STREET AND NUMBER					imo	re	F			the CITI	ZEN OF V	1 XYES 2 WHAT COUNTRY?	-
						1"	212			- 1	tog. Citt	USZ		
2421 Har	Tem A											057	н.	
11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES 2 X			II yes, s	pecify Cubi	n, Maxica	NIC ORIGIN? (Sp in, Puerto Ricen,		or No—	Black	E — American Inc k, Whits, atc.	Han,
3 Widowed 4 Di	porced	IF TES, GIVE	MAN ON DATES			I L YES	2 3 (HO	Specif	у:			Spec	Blac	k
15. DE	CEDENT'S EDU	CATION COMPRISED		DECEDENT'S					16b. KINC	OF BUS	INESS/INC	USTRY		
Elementary/Secondary		College (1-4 or 5		ife. Do NOT u	se retired.)	ouring m	OST OF WORKS	'y		So	hoo	3		
12th		5 +		Tea	che	r				50	1100	_		
17. FATNER'S NAME (First,	Middle, Last)						18. MOT	NER'S NA	ME (First, Middle,	Maiden S	Surname)			
Thomas P	atters	son					Не	nri	etta (ovi	ngt	on		
19a. INFORMANT'S NAME	(Type/Print)			19b. MAILING	ADDRES	S (Street	and Numbe	or Rural	Route Number, Cl	tv or Town	State. Zio	Codel		3
David Ro		n						Av	enue,			_		07
20a. METHOD OF DISPOS 1 De Burlai 2 Croma		oval from State	cemetery c	E AND DATE	other place	1			DATE		ATION —			
4 Donation Oth		_	Wood	llawn	Ce	met				Ba1	tim	ore	,Mary1	and
21. SIGNATURE OF FUNEF	IAL SERVICE LIC	CENSEE	10.	0-1-1	1 22 L	ERO	Y O	SS OF FA	ETT &	SON	FU:	NER	AL HOM	E
	1) (1	<i>O.</i>	NU	(XX)	4	600	LIE	ERT	Y HEIG	TTS	AV	ENU:	E 212	07
Sequentielly list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in the initiated events resulting in death) LA	itions, ediete YING jury	b. DUE TO	O (OR AS A CONS	SEOUENCE O	PF):			3000						
PART II. Other signific	cent condition	as contributing to	death but no	t resulting	in the u	nderlyir	ng ceuse	given in		WAS AN / PERFORI	MED?	246	D. WERE AUTOPSY AMAILABLE PRIO COMPLETION DI DF DEATH? 1 YES 2	F CAUSE
DID TOBACCO	USE CONT	RIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆	NO [J UNG	CERTAI	N 🗆					
25. WAS CASE REFERRED	TO MEDICAL		26. PL	ACE OF DEA	ATH (Check	k only one)							
EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHE		me 5 MR	aaldenca	6 Other (Spe	icify)				
27. MANNER OF DEATN		28a. DATE O		28b. TIR	AE OF	28c. IN	JURY AT		28d. DESCRIB		JURY OC	CURED		
	Pending	(MONTA, 1	Day, Year)	IN	JURY		ORK? YES 2 [NO						
2 Accident Investigation 3 Suicide 6 Could not be detarmined detarmined 4 Nomicide 7 Nomicide 1 Nomicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, etreet, factory, office City or Town, State) 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)														
29a. CERTIFIER (Check only	RTIFYINO PNYS	ICIAN: To the best of											a) and manner as	dated
			/							,, etc.				
29b. SIGNATURE AND THE	LE OF CERTIFIE	A Sth	1					C.M					14, 19	
30. NAME AND ADDRESS	OF PERSON WN	O COMPLETED CAL	JSE OF DEATH (I	TEM 27) (Typ	e, Print)									
DOWELL DATE EN ED (MONTH) DO	R	Fowler	ABIO CIONATION		Pen	n S	tree	et,	Baltir	nore	e, M	ary	land 2	120
31. DATE FILED (Month, De		32. REGISTR	AR'S SIGNATURE											
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page is may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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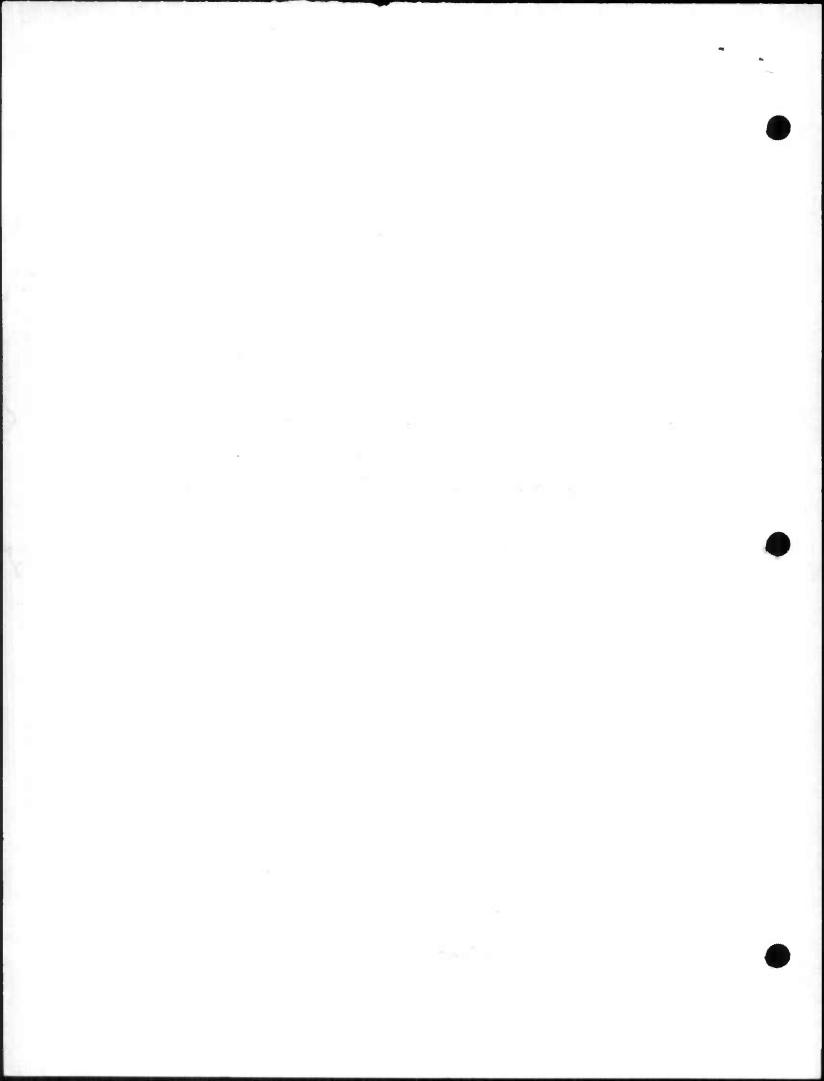
8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OFATH YEAR SUTTON WILLIAM October 17 1995 4:15 AM 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Aug 31, 1916 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 215-05-4963 79 Maryland 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3510 Chapman Rd. Randallstown Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Randallstown 1 YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3510 Chapman Rd. 21133 USA 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian Black, White, etc. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married Specify: 3 🔀 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Mechanic Heating & Air Conditioning 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Howard Sutton Ethel Bowen 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1395 Peace Dr. Mr. George W. Sutton Pasadena, MD 21122 20e. METHOD OF DISPOSITION
1 X Burlst 2 Cremetton 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Druid Ridge Cemetery 10 - 19Pikesville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23. PART I this the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory streat, shock, or heart failure. List only one cause on each line. Approximats interval Between Onset and Death IMMEDIATE CAUSE (Finel base of disease or condition ok the 6 month. DUE TO (OR AS A CONSEQUENCE OF reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) DUE TO (OR AS A CONSEQUENCE OF) OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in daeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES A NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one EXAMINER? HOSPITAL OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY Natural 5 Pending M 1 YES Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 6 Could not be determined 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the bests of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and menner se stated. 20th SIGNATURE AND LITTLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 10/18 4217 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kd 306 Juno

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32. REGISTRAR'S SIGNATURE



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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing a not after	10 THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perne filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR		STATE OF I	MARYL				T OF H E OF			MENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First,	Middle, Last)									2. DATE OF DEATH		YEAR	3. TIME OF DEATN
		Antonio	L.	Do	s Sa	nto	S			October 1			5a.m. ⋈
4. SOCIAL SECURITY NUMB	ER	5. SEX 6. AGE (In yrs. last birthday) F UNDER t YEAR F UNDER 24 HRS. 7. DATE OF BIRTTN 8. BIRTTNPLACE (Statu						NPLACE (State or Foreign					
And an estate the state of the					Bra	azil							
9a. FACILITY NAME (If not in	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH							DEATH					
4462 Louisv		oad				I	inks	burg			Car	rol1	
10a. STATE	10b. COUNTY	Υ			t0c, CIT	Y. TOWN	OR LOCAT	ION				_	10d. INSIDE CITY
Marvland	Carr	·o11					ıksbu						LIMITS?
10e. STREET AND NUMBER								ZIP CODE			10g. C1T	IZEN OF	WHAT COUNTRY?
4462 Loui	sville	Rd.						2104	8		υ	ISA	
11. MARITAL STATUS 1						ik, White, etc.							
	EDENT'S EDU			18a. DE	CEDENT'S	USUAL 6	OCCUPATIO	N st of workin	а	16b, KIND OF BU			
Elementary/Secondary (0)-12)	College (1-4 or 5	+)	lite.	Do NOT u	se retired.)			Seafare	ers l	nter	national
none				Mer	chan	ıt Se	eamar	l .		Ţ	Jnion	1	
17. FATNER'S NAME (First, M	liddle, Lest)							18. MOTI	NER'S NA	ME (First, Middle, Maiden	Surname)		
Antonio Do	s Sant	os						Sa	rah	Unknown			
19a. INFORMANT'S NAME (Type/Print)			198	. MAILING	ADORES	SS (Street a	nd Number	or Rural	Route Number, City or Tow	n, State, Zi	ip Code)	
Mrs. Angela	Dos S	Santos		4	462	Lou:	isvil	le R	d.	Finksburg	, MD	21	1048
20a. METNOD OF DISPOSIT 1 M Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 🗆 Rem	oval from State					oria		ck				own, Stata
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Loring Byers Funeral Directors, Inc. 8728 Liberty Rd Randallstown, MD 21133-4784													
,	eart failure.	complications the List only one car	et coused use on e	the de ech line	sth. Do	not ente	r the mo	de of dy	ng, suc	h as cardiac or resp	iratory s	rrest,	Approximets Interval Between Onset and Death
disease or condition resulting in death) . Congesture Cardiomohalty													
Sequentielly list conditions, If smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events													

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L.

0

PERSONNED SY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 - NO

WAS CASE REFERRED TO MEDICAL	28. PLAC	28. PLACE OF DEATH (Check only one)										
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 Nu	R: rsing Nome 5 Residence	8 Other (Specify)								
MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. OESCRIBE NOW INJURY OCCURED								

27. MANNER (Month, Day, Year) INJURY 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 28a. PLACE OF INJURY - At home, larm, atreet, lactory, office S Could not be datermined

WORK? М 2 NO

281, LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER
(Check only one)

A MEDICAL EXAMATE. On the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the lime, data and place, and due to the ceuse(e) end manner ee stated.

T. Kaloo	for
NAME AND ADDRESS OF DEDSON WHO	COMPLETED CALLER OF DEATH O

KAWAJA

29c. LICENSE NUMBER D25 11 5310 Nd Coln

29d. DATE SIGNED (Morth, Day, Year, 16 10

32 REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the attending physician and comple

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	SH A)IREC	Sund	E
	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-14 hours after death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	E HC	E FU	d wit	FITA
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REGISTRAR				ICATE OF		MENTAL HYGIEI REG. NO			
1. DECEDENT'S NAME (First, Middle, Last ALBERT	В.		SHIEL	DS J	r.	2. DATE OF DEATH	T995	YEAR	3. TIME OF DEATH 9:50 am
4. SOCIAL SECURITY NUMBER 214-12-1895	5. SEX 1 X M 2 D F	6. AGE (In yrs. last	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12/28/19	19	Countr	PLACE (State or Foreign y) yland
9e. FACILITY NAME (If not institution, give					on Location of D	EATH		NTY OF D	
Saint Joseph Med			10c. CIT	Y, TOWN OR LOCA	TION				10d, INSIDE CITY LIMITS?
	timore		(Catonsv	rille		10a. CIT	IZEN OF W	1 YES 2 NO
5 Rumford Dri	ve				21228		US		
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		T EVER IN U.S. ARI YES 2 N IN OR DATES		If yes, sp	CENDENT OF HISPA ecify Cuben, Mexic 2 NO Speci	NIC ORIGIN? (Specify Year, Puerto Rican, atc.)		14. RACE	- American Indian, t, White, atc. by: White
				USUAL OCCUPATION OF MORE MORE MORE MORE MORE MORE MORE MORE		16b. KIND OF BI	JSINESS/IN	DUSTRY	willte
Elementary/Secondary (0-12)	College (1-4 or 5	·) life.	Do NOT us	e retired.)	ist or working	7			
12th 17. FATHER'S NAME (First, Middle, Last)		Sa.	lesma	in	18. MOTHER'S N	Busine		quipn	ent
Albert B.	Shields				Marie	T. McNal	ly		
19e. INFORMANT'S NAME (Type/Print)						Route Number, City or To			24 220
Timothy Shields 200. METHOD OF DISPOSITION				Teasant propertion (No		Dr. Catons	OCATION -		
1 Buriel 2 Cremation 3 Re 4 Donation 8 Other (Specify)	moval from State	cemetery, cres	metory or of	her place!		10/17 Ba			
21. SIGNATURE OF FUNERAL BERVICEA	1. In	de		David	J. Webe	r Funeral n Ave. Bal	Home		
23. PART I. Enter the diseases, of shock, or heart fellure	complications tha	t coused the dec	eth. Do n	ot enter the mo	de of dying, suc	ch ee cerdiac or reep	olratory ar	reet,	Approximete
iMMEDIATE CAUSE (Final disease or condition resulting in death)	ARTERIO	DSCLERO	тс с		SCULAR D	DISEASE			Interval Betwee
Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF):								
if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury	6	(ON AS A CONSEC	DENCE OF):					
that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CONSEO	UENCE OF	ን:					
PART II. Other significent condition ACUTE RENAL FA		deeth but not re	eaulting i	n the underlying	g cause given in		MMED?	24b.	WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEAT	TH YE	s □ NO □	UNCERTAI				1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	E OF DEAT	DEATH (Check only one)					
27. MANNER OF DEATH	28e. DATE OF (Month, D	INJURY	28b. TIMI	E OF 28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OC	CURED	
2 Accident Investigation 3 Suicide 8 Could not be 4 Hornicide determined	28e. PLACE O	F INJURY — At honetc. (Specify)	me, ferm, s		YES 2 NO	281. LOCATION (Street City or Town, State	and Number	r or Aurel A	oute Number,
						to the cause(e) end ma			and manner on etct-4
29b. SIGNATURE AND TITLE OF CERTIFI				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	29c. LICENSE NU		29d. DAT		The state of the s

31. DATE FILED (Month, Day, Year)
OCT 1 8 1995

32. REGISTRAR'S SIGNATURE

AND CONTRACTOR OF THE PERSON

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EF, A. A. SELL II.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

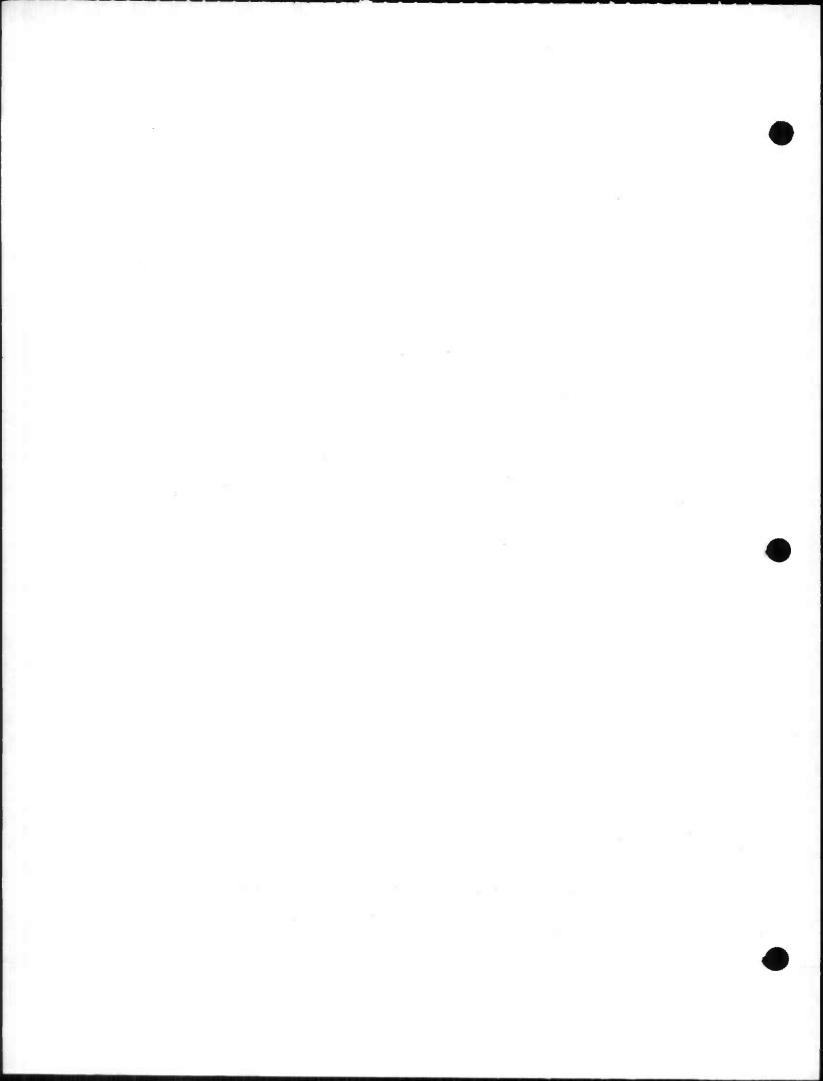
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G-762 reb FOR G-762 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR I Lem: 7, per informant 8/7/98 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 1995 oct. 17 12:20 A .. SCHAFFER ALFRED JOHN 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1/10/28 IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 214-22-9816 1X M 2 F 1928 Maryland 67 June Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore County DIRECTOR Towson Stella Maris Hospice RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 18b. COUNTY 10d, INSIDE CITY 1 X YES 2 NO Baltimore City Maryland N/A FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21206 U.S.A. 5443 Whitwood Road 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO 14. RACE -- American Indian, Black, White, etc. 1 Never Merried 2 Married JE YES, GIVE WAR OR DATES BY White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Fire Fighter Baltimore City Year 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Clara May Eck Alfred Thomas Schaffer 8 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5443 Whitwood Road, Baltimore, Maryland 21206 Bonnie Mae Schaffer 20b. PLACE AND DATE OF DISPOSITION (Name of 10/19/95) ATE Cardens of Faith Cemetery 20s. METHOD OF DISPOSITION
1XI Burlsi 2 ☐ Cremetion 3 ☐ Removal from State 20c. LOCATION - City or Town, State Baltimore, Maryland 4 Donetion 6 Other (Specify) John C. Miller, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 6415 Belair Road, Baltimore, Maryland 21206 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) UNG CAUCER CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO TES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 6 Specify) 4 Nursing Home 5 Residence Hospice 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26c, INJURY AT WORK? 284, DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO BY Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 띪 195 00 17

DR. KENDALL FAULKNER 3 DEGISTIDAR'S GIVE UPE

2300 DULANEY VALLEY RD., TOWSON, MD



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DIVISION OF VITAL BECORDS P.O.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO).		
		1. DECEDENT'S NAME (First, Middle, Last)	0 7	122			2. DATE OF DEATH	DAY	3. TIME OF DE	EATN ///
		JAMES 4. SOCIAL SECURITY NUMBER		1BBS			October	10	43	Maler
		DIE IS TONO	132 M 2 □ F	(In yrs. lest birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		. BIRTHPLACE (State or Country)	Foreign
should		9a. FACILITY NAME (If not institution, give at	0	O this.	Oh CITY TOWAL	OR LOCATION OF DE	1101.91	114	NIGGIU.	PI
2, 3 sht	NO B	HARFORD ME		LATIAZO	HAVE			HA!	Y OF DEATH	
-	5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY					2777	1 (10		
Pages	DIRECTOR	Marylan Has		10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CI LIMITS?	
permit		10a. STREET AND NUMBER	F0100		1017 HI	ZIP CODE		100 CITIZE	1 TYES 2 TEN OF WHAT COUNTRY	
. <u>\$</u>	FUNERAL	1706 RUFFS	17,11 R	CAC		21012		ing. Grize	.S.A.	•
UZU physician. burial-transit		11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPAN	NC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No- 1	4. RACE — American In Black, White, etc.	idlen,
	BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			Z NO Specify			Specify:	
hospital or attending arched for use as the	9	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16e. DECEDENT'S	USUAL OCCUPATION	ON et al working	16b. KIND OF BU	SINESS/INDU	BTRY	
ital or	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	C				
he hospit detached once.	COMPL	17. FATNER'S NAME (First, Middle, Last)		HZGVZY	SACIFE	201018	REJELE	J. 201	FSIOSE	00-
# E &		Graphic Mc	Kinley T	2005		MOTHER'S NA	ME (First, Middle, Maiden	~	11:00	
retained 5 should	BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	nd Number or Rural F	Poute Number, City or Tox	vn. State. Zio C	ode)	
2 - 0 5	욘	LORSTTA M. H	UBER	1706	RUFFS	MILL.	A. Im.	ELAin		1015
F 8 8		20a. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Remo		b. PLACE AND DATE		me of	DATE 20c. LC		ly or Town, State	01)
Page 6 ma il director, p		4 Donation 6 Other (Specify)		TREEN Crematory or o	Janu	ERLMAN	SAY POT	BALTO	. Mo.	
24 hours after death. Page 6 m filled in by the funeral director, on, or removal.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FA	RAL CHA	PSI-1	BULAIR,	PA
er death. the funeraval. if exami		Karle 45	1 mon		30	SWPAR	T DRIV	E For	KIH TZZS	MO.
ours after of in by the or removal.		23. PART I. Entar the diseases, or cahock, or heart failure. I	omplications that cause	ed the death. Do r	not anter the mo	da of dylng, auci	h ae cardiac or reap	iratory arres		
y filled in tion, or the m		IMMEDIATE CAUSE (Final	ALA.	1 .	# 0					Batween nd Death
od within 24 ompletely fille if, cremation, event, the		disease or condition resulting in death)	Aprioun	mallion	THE W	ruurik	un.	1.		
	_	_	ANIMALIE	A Char	in h who	tracti	4.0.	dise	ase	
te be executed rision to burial, traumatic en	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO OR AS	CONSEQUENCE OF	me cops	wucuu	efreemou	any		
r tra	CA	cause, Enter UNDERLYING CAUSE (Disease or Injury	Anlenosch	enolic C	andour	stallar	- disea	se		
n certificat nding phy Hygiene p	RTIFI	that initieted eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUÊNCE OF):							
	CER	L								
in the		PART II. Other algnificant conditions	contributing to death i	but not reaulting	In the underlying	cause given in	Part I. 24e. WAS AN		24b. WERE AUTOPSY	
	DICAL						PERFOR		AVAILABLE PRIO COMPLETION DE OF DEATH?	
w requires that been signed to the or Health a shows any	ME								1 TES 2] NO
has bee Dept. o		DID TOBACCO USE CONTR	IBUTE TO CAUSE C	OF DEATH YE	S NO	UNCERTAIN	1 1			
# a a 5	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:					
SICIAN: The certificate the State	HYS	1 YES 2 NO	1 Impatient 2 ER/Out		4 Nursing Nom	5 🗆 Residence				
F state	D.	Hatural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	PES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUI	łED	
J G K D M	D BY	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, s	street, factory, office		261. LOCATION (Street City or Town, State)	end Number or	Rural Route Number,	
OR ATTEN DIRECTOR: hours after Item 28	ETE.	4 Homicide defermined								
E AR =	COMPLET	(Check only	CIAN: To the best of my know							
HOSPITAL FUNERAL Within 72 TTANT: If			t: On the basis of examination	on and/or investigation	n, in my opinion, de					stated,
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Lu	Mi	0-	29 LICENSE NUM	161	29d. DATE S	HIGNED (Month, Day You	7
E E B E	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (TEM 27) (Type,	Print)	7/1	60		11000	
		NT LER	3075	Ulwe	nAO	e .ktal	re do c	FIRE	8 M1	2
.		OCT 1 8 1995	LA STREET LAND	W. T.					200	74
		0012 01000							-000	. 00

OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death, Page 6 may be retained by the hospital or attending physician.	URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should not be more after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	NT. Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
O THE HOSPITAL OR ATTEN	D THE FLINERAL DIRECTOR	MPORTANT: If item 28

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	O' 11 E O 1		A			
	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH
- 3	GERTRUDE RUTH	EY TORK	RET			OCTOB &	r 12, 19	195 YEAR	10:10 p M
15	4. SOCIAL SECURITY NUMBER 5. SEX		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I		10	HPLACE (State or Foreign
- 1				MONTHS DAYS	HOURS MIN.	(Month, De	sy, Ybar)	Cour	ntry)
	219-30-7323 1 DM	2 MF 86	YRS.			July	10,190	9	Maryland
	9a. FACILITY NAME (If not institution, give street and no	ımber)		9b. CITY, TOWN	OR LOCATION OF	DEATH	Sc. Ct	DUNTY OF	DEATH
Œ	Augsberg Lutheran	Home		Baltin	moro		Da.	1 + 1 m	ore County
DIRECTOR	RESIDENCE OF DECEDENT	nome		Dalti	MOTE		Da.	LULI	ore county
	10a, STATE 10b, COUNTY		10c, CIT	, TOWN OR LOCA	ATION				10d. INSIDE CITY
<u>a</u>									LIMITS?
	Maryland Baltimo	re Coun	ty Ba	altimo					1 YES 2 NO
FUNERAL	10s. STREET AND NUMBER				Of. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?
# 1	6811 Campfield Roa	ıd			21207			USA	
ŽΙ		DECEDENT EVER IN	II S ARMED	13 WAS DE	CENDENT OF HISP	NIC OBIGIN? (9	inacify Yes or No-	7	CE — American Indian,
립	1 Never Married 2 Married FORG	CES? 1 YES	2 NO		pecify Cuban, Mexic			Bie	ck, White, etc.
BY	3 X Widowed 4 Divorced	S, GIVE WAR OR DA	TES	1 D YE	S 2 10 NO Spec	eity:		Spe	ocity:
	O. T. C. C. C. C. C. C. C. C. C. C. C. C. C.			1					White
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		18a. DECEDENT'S	USUAL OCCUPAT	TON	16b, KIP	NO OF BUSINESS!	NDUSTRY	
		(1-4 or 5 +)	ille. Do NOT us	e retired.)	lost or working				
2		(1-013+)	sal	96		sa	les re	tai1	0-1/1/1/1
Σ	Unknown		241	-0	I as				
COMPLET	17. FATHER'S NAME (First, Middle, Last)						lle, Maiden Surname)	
BE	Arthur Rowland Rut	ley			Cath	erine	Wolfe		
	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street	and Number or Rura	I Route Number,	City or Town, State,	Zip Code)	21043
2	Ms. Mary Kathryn	Torbet	5490	Green	Dory	ano C	iolumbi	2 1	Maryland
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Removal from		PLACE AND DATE		Vame of	DATE	20c. LOCATION	— City or	Town, Stata
	4 Donation 5 Other (Specify)				Crematory	10-14-99	Taure1	Mary	land
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME	AND ADDRESS OF	ACILITY			
i	1 0 1	M00544		Stack	Funeral H	tome. P.7	A.		
	11) - H 1 -			1000000					
		4.3		Filio	ntt Citu	Marriland	3 210/13		
	23. PART I. Enter the dissesses, or complice	tions that caused	the death. Do r		ott City,			arrest	Approximate
	23. PART i. Enter the diseases, or compiles shock, or heart failure. List only		ech line.	ot anter the m	ode of dying, su			arreat,	Approximata interval Between
	shock, or heart fellure. List only IMMEDIATE CAUSE (Fine)		ech line.	ot anter the m	ode of dying, su			arreat,	
	shock, or heart fellure. List only IMMEDIATE CAUSE (Fine) disease or condition		ech line.	ot anter the m	ode of dying, su			arreat,	interval Between
	shock, or heart fellure. List only IMMEDIATE CAUSE (Fine)	one couse on or	ech line.	not anter the m				arreat,	interval Between
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Paltimore-Washing.

Wm. B. Smith

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: II Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HO	TO THE FU!	be filed with	IMPORTAL

	1 - FOR STATE REGISTRAR	ATE OF MARYLAND / I	DEPARTMENT O		MENTAL HYGIEN	E			
	1. OECEDENT'S NAME (First, Middle, Last)	Thompson		4	2. DATE OF OEATH MONTH D	169	3. TIME OF DEATH		
	217 20 1175	M 2X F 70	YRS. MONTHS DA	YS HOURS MIN.	7. DATE OF BIRTH Dec 29, 19	24 M	BIRTHPLACE (State or Foreign Country) aryland		
TOR	9a. FACILITY NAME (If not institution, give street and Sinai Hospital RESIDENCE OF DECEDENT	number)	Balti	MOTE	ATH	N/A	OF OEATH		
DIRECTOR	10e. STATE 10b. COUNTY Maryland N/	A	10c. CITY, TOWN OR L				10d. INSIDE CITY LIMITS? 1		
FUNERAL	100. STREET AND NUMBER 848 W. 3	5th Street		10f. ZIP CODE 21211		U.S.	OF WHAT COUNTRY?		
BY FUN	1 T Never Married 2 Married FC	AS OECEOENT EVER IN U.S. ARM DRCES? 1 TYES 2 TO NO YES, GIVE WAR OR DATES) If ye	DECENDENT OF HISPAN a, specify Cuban, Mexica YES 2 NO Specify	n, Puerto Rican, etc.)	or No.— 14.	RACE — American Indian, Black, White, atc. Specify: White		
COMPLETED		(Giv ide. (i	EDENT'S USUAL OCCU s kind of work done during Do NOT use retired.) nemaker	PATION g most of working	Own Ho		TRY		
	6 17. FATHER'S NAME (First, Middle, Lest) Bernard S. Thomps		nemare:		ME (First, Middle, Maiden Jennings				
TO BE	10a. INFORMANT'S NAME (Type/Print) Helen E. Krebs	19b. 8a	MAILING ADDRESS (SE 48 W. 35th	Street, B	Route Number, City or Tow Saltimore,	n, Stete, Zip Coo Maryla	ond 21211		
i	20a. METHOD OF OISPOSITION 1/ Burlet 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	cemetery, crem Dulan			0/18/95 Cd	ckeysv	or Town, State ville, Maryland ome		
	23. PART I. Enter the diseases, or compile	cations that coused the dea	381	8 Roland A	ve, Baltin	nore, M	laryland 21211		
	shock, or heart failure. List or	nly one cause on each line.					Interval Between Onset and Death		
Z		HYPOXEMI	UENCE OF):				hours		
CERTIFICATION	Sequentially list conditions, if sny, leeding to immediate cause. Enter UNDERLYING PNE UMONIA CAUSE (Please of the Public Control of the PNE UMONIA)								
SERTIF	that initiated events resulting in death) LAST	that initiated events DUE TO (OR AS A CONSEQUENCE OF)							
PHYSICIAN: MEDICAL	PART II. Other significant conditions conf				Part I. 24a, WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
IAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25, WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one)								
YSIC	1 YES 2 NO 1 TO	SPITAL: Inpetient 2 ER/Outpetlant 3		Home 5 🗆 Residence					
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	INJURY	WORK?	28d. DESCRIBE HOW	INJURY OCCUR	ieo		
0	2 Accident 3 Suicide 8 Could not ba 4 Homicide City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route City or Town, State)								
COMPLET	nee)	To the best of my knowledge, dea the basis of exemination and/or in					ause(s) and manner as stated.		
BE	SHOW AND THE OF CETTERIES			29c. LICENSE NU AS 240 2 3	MBER 321 H49712	29d. DATE S	IGNEO (Month, Def. Year)		
10	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITEM DO SINA!		L BA	ND ZI	215			
	OCT 1 8 1995 Jalu	3 REGISTRAR'S GNATURE							

2 m · An

BALTIMORE, MARYLAND 21215-0020 ter death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

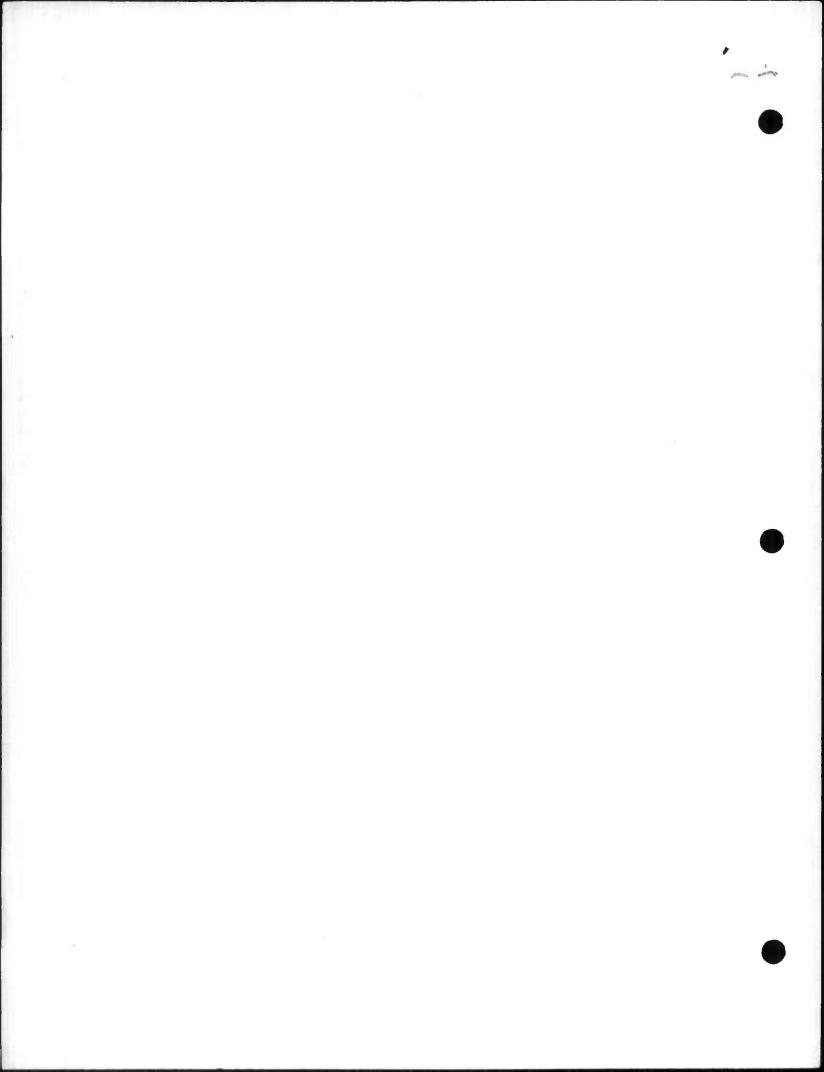
DIVISION OF VITAL RECORDS, P.O. BOX 68760

DALLINONE, MARTLANE	24 hours after death. Page 6 may be retained by the hosp	filled in by the funeral director, page 5 should be detache	on, or removal.	ne medical examiner must be notified at once.
Control of the Contro	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

- 1	REGISTRAR CERTIFIC	MIL OI DEMIII	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) GEORGE LUTHER WASHINGTON		2. DATE OF DEATH OCTOBER 1	5, 1995	3. TIME OF DEATH 12:14 AM M	
		UNDER 1 YEAR IF UNDER 24 HRS. MITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) (Man 27)		HPLACE State or Foreign	
	9s. FACILITY NAME (If not institution, give street and number) 9t	CITY, TOWN OR LOCATION OF DE		9c. COUNTY OF DEATH		
DIRECTOR	GREATER BALTIMORE MEDICAL CENTER	BALTIMORE		BALTIMORE		
<u> </u>	100. CITY, T		10d, INSIDE CITY			
	10g STREET AND NUMBER	Dalto			1 YES 2 NO	
FUNERAL	3507 Ellamont Rd	101. ZIP CODE	115	10g. CITIZEN OF	VHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANI If yes, specify Cuban, Mexican 1 YES 2 NO Specify:	, Puerto Rican, etc.)	or No.— 14. RAC Blac Spec	E - American Indian, ik, Winte, etc.	
ETED		done during most of working	16b. KIND OF BUS	INESS/INDUSTRY).1.61	
COMPLETED	2 5t Tea	cher/Adminst	h Dal	to t	ublic Joh.	
ш	Cornelius J. Washinston	18. MOTHER'S NAM	IE (First, Middle, Meiden :	Surneme) 4		
0		DRESS (Street and Number or Rural Re	oute Number, Gity or Town	(State, Zip Code)	md 71715	
	206. PLACE AND DATE DED	nincel	915/45 LOC	ATION - Pity or Ti	own, Stata	
	1. SIGNATUREOF FUNERAL SERVICE LICENSEE	22 NAME AND ADDRESS OF FIG	LITY	L	wn, ma	
_	· Mefrue D. Dott	4300 LB	pash	Ave	7.7.1	
ı	23. PART Enter the diseases, or complications that caused the death. Do not shock, or heart feliure. List only one cause on each line.	enter the mode of dying, such	as cerdlec or reepir	atory arrest,	Approximate Interval Between	
	disease or condition resulting in death) s. ISCHEMIC (TOXIC	METABOLIC	ENCEP	HALOPA	Onset and Death	
	DUE TO (OR AS A CONSEQUENCE OF):			11/20/11		
CATION	Sequentially list conditions, if any, leading to immediate DIFFUSE OEREBRA DUE TO (OR AS A CONSEQUENCE OF):					
2	CAUSE. (Disease or Injury that Initiated events. Due To (OR AS A CONSEQUENCE OF):	AKTERW SCLE	nosis			
CERTIFI	resulting in death) LAST					
- II	PART II. Other algorificant conditions contributing to death but not resulting in ti	ha undarbilan asusa abusa la E				
		ing mingerianis canse diseu in b	art I. 24a. WAS AN		. WERE AUTOPSY FINDINGS	
DICA	ENO STAGE RENAL DISEASE	ne underlying cause given in P	24a. WAS AN A PERFORM	AED?	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDI	ENO STAGE RENAL DISEASE		PERFORI	AED?	AMILABLE PRIOR TO COMPLETION OF CAUSE	
MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 26. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (□ NO 🗹 UNCERTAIN	PERFORI	AED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 26. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER PROPERTY OF THE	□ NO □ UNCERTAIN Check only one) THER:	PERFORI	AED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Ponding 28. DATE OF INJURY (Morth, Dey, Vear) 28b. TIME OF INJURY	UNCERTAIN Check only one) THER: Nursing Home 5 Residence 6 F 28c. INJURY AT WORK?	PERFORI	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 28. DATE OF INJURY (Month, Dey, Near) 1 Netural 28. PLACE OF INJURY (Month, Dey, Near) 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - At home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree 28. PLACE OF INJURY - AT home, farm, stree	Check only one) THER: Nursing Home 5 Residence 6 F 28c. INJURY AT WORK? M 1 YES 2 NO	PERFORI	JURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 28. DLACE OF INJURY (Month, Day, Vear) 28. DLACE OF INJURY 28. DL	Check only one) THER: No UNCERTAIN THER: Nursing Home 5 Residence 8 F	PERFORI 1 YES 2. Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	JURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lent 2 ER/Outpatient 3 DOA 4 TO INJURY 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY At home, farm, stree building, etc. (Specify)	UNCERTAIN Check only one) THER: Nursing Home 5 Residence 6 F	PERFORI 1 YES 2. Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	JURY OCCURED and Number or Rural I	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Pending Investigation 3 Suicide 4 Could not be 4 Homicide 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY	UNCERTAIN Check only one) THER: Nursing Home 5 Residence 6 F	Other (Specify) 28d. DESCRIBE HOW IN City or Town, State) o the cause(s) and menr me, dats and place, and	JURY OCCURED and Number or Rural I	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	
D BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Pending Investigation 3 Suicide 4 Homicide 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At home, farm, stree building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in 29b. SIGNATURE AND TITLE OF CERTIFIER 3. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	Check only one) THER: Nurning Home 5 Residence 8 F 28c. INJURY AT WORK? M 1 YES 2 NO It, factory, offics It the time, data and place, and due to many opinion, death occured at the file of the property of the time.	PERFORI 1 YES 2. Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street ar City or Town, State) the cause(a) and ment me, data and place, and DER	JURY OCCURED and Number or Rural is the cause(s) JURY OCCURED And Number or Rural is And Number o	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	
J BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Netural 3 Sulcide 4 Homicide 5 Pending Investigation 3 Sulcide 6 Could not be detarmined 28e. PLACE OF INJURY (Month, Day, Vear) 28e. PLACE OF	Check only one) THER: Nurning Home 5 Residence 8 F 28c. INJURY AT WORK? M 1 YES 2 NO It, factory, offics It the time, data and place, and due to many opinion, death occured at the file of the property of the time.	Other (Specify) 28d. DESCRIBE HOW IN City or Town, State) o the cause(s) and menr me, dats and place, and	JURY OCCURED and Number or Rural is the cause(s) JURY OCCURED And Number or Rural is And Number o	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	





FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CER	TIFICATE	OF DEATH	REG. NO).	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN
		Frances E	Weihrauch					3 19°	65 0.30 A M
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birt	thday) IF UNDER 1	YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6.1	BIRTNPLACE (State or Foreign
		215-10-5003	1 M 2 F	85	YRS. MONTHS E	DAYS HOURS MIN.	Jan 19, 19		Country)
3 should		Se. FACILITY NAME (If not institution, give st	22	0.5	9b. CITY. T	TOWN OR LOCATION OF D		9c. COUNTY	laryland
38	Œ	Union Memor:					EAIR		
1, 2,	СТОВ	RESIDENCE OF DECEDENT	rar mosh			lto City		N/A	
Pages 1	W	10e. STATE 10b. COUNTY	Y	10	c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY
Ž.	뜸	Maryland	N/A	F	Baltimore	0			LIMITS?
permit.		10e. STREET AND NUMBER	11/ 42		Jaicamor	10f, ZIP CODE		T 40- CITIZEN	OF WHAT COUNTRY?
is.	FUNERAL	600 W. 33rd				212	211	U.S	
020 physician. burlal-trar	5	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES	IN U.S. ARMED		AS DECENDENT OF NISPA	NIC ORIGIN? (Specify Ye	18 or No- 14.	RACE — American Indian, Black, White, etc.
	BY	1 Never Merried 2 Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES		YES 2 X NO Specif			Specify: White
JAND 21215-0 the hospital or attending detached for use as the once.		15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECED	ENT'S USUAL OCCI	UPATION	16b. KIND OF BU	JSINESS/INDUST	
TO III		Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do I	NOT use retired.)	ing most or working			
AND he hospite detached detached	COMPLET	10		Secre	tary		Reever,	Cooper	& Brass
A he he he detax	Ö	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Meiden	n Surneme)	
# 8 6 E	BE	William F.	Evert				eth Armacos		
MAK retained 5 should notified		19e. INFORMANT'S NAME (Type/Print)		19b. M/	AILING ADDRESS (6	Street and Number or Rural	Route Number, City or Tov	wn, State, Zip Coc	(e)
M e rett	임	Emily Evert				d Street, E			
may be		20s. METHOD OF DISPOSITION XX Burlel 2 Cremation 3 Remo	20/		DATE OF DISPOSITI		DATE 20c. LC		
must CH		XXBuriel 2 Cremation 3 Remo	oval from State Car	metery ecomoto	on, or other olegal				e, Maryland
Page I dire		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NA	ME AND ADDRESS OF FA	ACILITY		
BALIIMOR hours after death. Page 6 ma ed in by the funeral director, p or removal. medical examiner must		1 1,0-	1. +	2	A. A	Alan Seitz,	JR. Funer	cal Home	e
or de the fr		M. My	Deity.	1	3818	8 Roland Av	re., Baltim	nore, Ma	arvland 21211
E 3 E B		23. PART I. Enter the diseases, or o	complications that cause List only one cause on e	d the deeth.	Do not enter th	ie mode of dylng, suc	ch as cardiec or resp	irstory arrest,	Approximate
filled in fon, or re		MINEDIATE CALIDE (Elect							Interval Between Onset and Death
F 5 6 7		disease or condition resulting in death)	DUE TO (OR AS A DUE TO (OR AS	tony	Failur	e			holf day
ted within completely ial, cremati, ti		resulting in death)	DUE TO (OR AS	A CONSEQUEN	NCE OF):				
executed with and complete o burial, crem	z		. Cerebella	· b	loodin	b			one do
and the mast	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUEN	ICE OF):	7			fen month
ज इंड द	Y.	cause. Enter UNDERLYING	a Ahilominu	1 m					Len month
		CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUEN	ICE OF):				
attending mal Hygier Y, or oth	RTIFI	resulting in death) LAST	1						
	S		3.						
at the dea by the art and Menta ny Injury,	AP.	PART II. Other significant condition	a contributing to death b	but not resul	iting in the unde	erlying couse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
a a a a	EDICAL	De Cubital	uller				PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE
requires that been signed of Health as shows am	MEC								OF DEATH?
St. 0 60 1		DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	OF DEATH	YES NO	O D UNCERTAL	N RI	- 1	I LI TES Z DINO
The law in the has be atte Dept.	IAN	25. WAS CASE REFERRED TO MEDICAL			F DEATH (Check only		17.24		
PHYSICIAN: The land this certificate has with the State Degrade, or Item 23	SICI	EXAMINER?	HOSPITAL:	netient 3 C	OTHER:	No. of Contract	(Franklaska)		
Sicial Si	РНҮ	27. MANNER OF DEATH	28e. DATE OF INJURY			g Nome 5 Residence	8 ☐ Other (Specify) 28d. DESCRIBE HOW I	IN HURY OCCUPA	
		1 Natural 5 Pending	(Month, Day, Year)	1	INJURY	WORK?	200. DESCRIBE NOW I	INJURY OCCURE	.0
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 28 is marked, or it	B	2 Accident Investigation	28e. PLACE OF INJURY	Y - At home (1 YES 2 NO		*** *** **	
OR ATTENDING DIRECTOR: After hours after death Item 28 is ma	8	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	icity)	Milin, Street, tectory	, office	26t, LOCATION (Street of City or Town, Stete)	end Number or is)	ural Route Number,
OR AT DIRECT hours a litem 2	Ш								
	COMPL		CIAN: To the best of my know						
HOSPITAL FUNERAL WITHIN 72 P	S	2 MEDICAL EXAMINER	R: On the besie of examination	m end/or inves	tigation, in my opin	ilon, death occured at the	i time, date end place, er	nd due to the ce	use(s) and menner es stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	Ш	29b. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUI	MBER	29d, DATE SIC	GNED (Month, Day, Year)
HT 00 SE	0	1ents N	x MD	1		4774	78946	10	113/65
E E E E	임	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	EATH (ITEM 27)	(Type, Print)	7.10	, 0	/	1 - 1 - 1 3
		ZAIQI WANG	The Union	mem		Hospital	Balt; mo	e, mi	> 21218
		OCT 1 8 1995	32, REGISTRAR'S SIGN	ATURE					
		0012 1333 J	THE REAL PROPERTY.	Mark					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEM:	19a,	PER	F.H.	FILM	G - 728	10/	19/95	t.t
FOR			STA	TE OF	MARYLA	ND /	DEPA	RTMI

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	OINTE OF IN	CE		ICATE				MEHIN	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
	EVELYN ALVERTA	ANDERSON	V						OCT		18,	1995	11:06 A.M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTI	IPLACE (State or Foreign
	077-10-5273	1 🗆 M 2 😾 F	87	YRS.	MONTHS	DAYS	HOURS	MIN,	FEE	h, Day, Year)	1908	MARY	
DIRECTOR	Se. FACILITY NAME (If not institution, give a	street and number)							UNTY OF D				
	7157 BALTIMORE & ANNAPOLIS BLVD. GLEN BURNIE ANNE AF								E ARI	JNDEL			
EC	10e. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
FIG	MARYLAND ANNE	ARUNDEL		GL	EN BU	RNTI	7						LIMITS?
BY FUNERAL	10e. STREET AND NUMBER			013.	Div Do		ZIP CODE	E	_		10g. CI	TIZEN OF	WHAT COUNTRY?
	7157 BALTIMORE &	ANNAPOLTO	S BLVD				2106	3.1			11	S.A.	
	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1 (MED			ENDENT C	F HISPAN		N7 (Specify Ye		14. BACI	E — American Indian,
	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WA		10			2 X NO	n, Mexica Specify		Ricen, etc.)		Spec	
ED	15. DECEDENT'S EDU		16e. DE	CEDENT'S	USUAL OC	CUPATIO	N .		168	. KIND OF BU	JSINESS/II		I.D
ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	life	ve kind of Do NOT u	work done d se retired.)	luring mo:	st of working	ng					
P	UNKNOWN	N/A		SALES	3				H	HUTZLE	RS		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA		Middle, Maide			
BEC	HARRY	NORRIS					ROS		ANNA	BERR	_		
10	196. INFORMANT'S NAME (Type/Print) LARRAINE KI	ENNEDY								ber, City or To			21061 BURNIE MD
	204_METHOD OF DISPOSITION		20b. PLACE	ND DATE	OF DISPOSI							- City or To	
	1 ABurlel 2 Cremetion 3 Rem	oval from State	MOUNT	mato Lori	VET				18%	51 BA	LTIMO	DRE.	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE					D ADDRE			HOVE			
	Home .	Zhaken	~							HOME	,	IRNTE	, MD 21061
	23. PART I. Enter the disesses, or	complications that	caused the de	eth. Do	not enter	the mo	de of dy	ing, suc	h ss can	dlec or res	piratory s	rrest,	Approximate
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one ceus	se on each line	1				0	1	1			Interval Between Onset and Death
	disease or condition resulting in death)	De	10/h	VI	1	-11	70	, V	0.1	1	las	1	
	resulting in destil)	DUE TO (OR AS A CONSE	DUENCE C	F): /	7)		-	8	9	1		
z	recognism artificial	b			6	_							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	DUENCE C	F):								
2	CAUSE (Disease or injury	c											
TE	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	DUENCE C	IF):								
H		d						-					
٦	PART II. Other algnificent condition	na contributing to	death but not r	eaulting	In the un	derlying	cause	given in	Part I.	24s. WAS A		Y 248	. WERE AUTOPSY FINDINGS
EDICAL										4 B yes a Films			AVAILABLE PRIOR TO COMPLETION DF CAUSE
ED										1 123	. Muo		OF DEATH?
Σ.	DID TOBACCO USE CONT	RIBUTE TO CA!	USE OF DEA	TH Y	ES 🗆 N	VO [1 UNC	ERTAII	N P				1 129 2 10
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				TH (Check		, 0111						
SIC	EXAMINER?	HOSPITAL:	ER/Outpetlant 3	□ DOA	OTHER	t:	0 .	aldense	4 □ Oth	er (Specify)			
ΗX	27. MANNER OF DEATH	28a. DATE OF I	INJURY	28b. TIR	E OF	28c. INJ	URY AT	and and		SCRIBE HOW	INJURY O	CCURED	
	1 Netural 5 Pending Investigation	(Month, De	ly, Year)	IN	JURY M		RK?	NO					
BY	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF	INJURY — At ho	me, form,	street, facto	ory, offic	1					er or Rural	Route Number,
COMPLETED	4 Homicide determined	building, t	etc. (Specify)						City	or Town, Sten	0)		
F	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of i	mv knowledge, de	ath occur	red at the ti	me data	and place	end due	to the ca	use(s) and m	enner ee s	teted.	
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	29b. SIGNATURE AND TITLE OF CERTIFIE							ENSE NUI					(Month, Day, Year)
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2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUS	E OF DEATH (ITE	M 27) (Typ	e, Print)						1	10-1	0 /3
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e iam requires that the beaut celumrate be executed whom 12 hours after beaut. Mage to may be retained by the hospital or attending phys	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria		1.23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The

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DIRECTOR: A hours after d

TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h

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31392 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OC T atherine Acord Hizabeth 10:43 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. last birthday IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗆 M 2 🖵 F 212-10-4999 83 April 1912 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 21229 DIRECTOR St. Agnes 900 Caton Avenue Baltimore RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Lansdowne 1 YES W NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 205 3rd Avenue 21227 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: BY 3 K Widowed 4 Divorced Specify: white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 lineworker Koppers 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname). John T. Hurley Sr. BE Margaret M. Wiedner 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Joann Zanfila Hollins Road Baltimore, Maryland21223 20e. METHOD OF DISPOSITION
1 \$\overline{\partial}\$ Burlal 2 \$\subseteq\$ Cremation 3 \$\subseteq\$ Removal from State
4 \$\subseteq\$ Donation 5 \$\subseteq\$ Other (Specify) \$\subseteq\$ 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State emetery, crematory or other place)
Meadowridge Memorial 10/20 Dorsey, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 23. DART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart fallure. List only one cause on each line. Intervsi Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition reaulting in death) uce Sequentially list conditions, BUE TO (OR AS A CONSEQUENCE OF): if any, iseding to immediata cause. Enter UNDERLYING CAUSE (Disesse or Injury bhi. DUE TO (OR AS A CONSEQUENCE OF) that initisted eventa resulting in death) LAST

CERTIFICATION PART ii. Other significant conditions contributing to dasth but not reaulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 M NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and menner as stated.

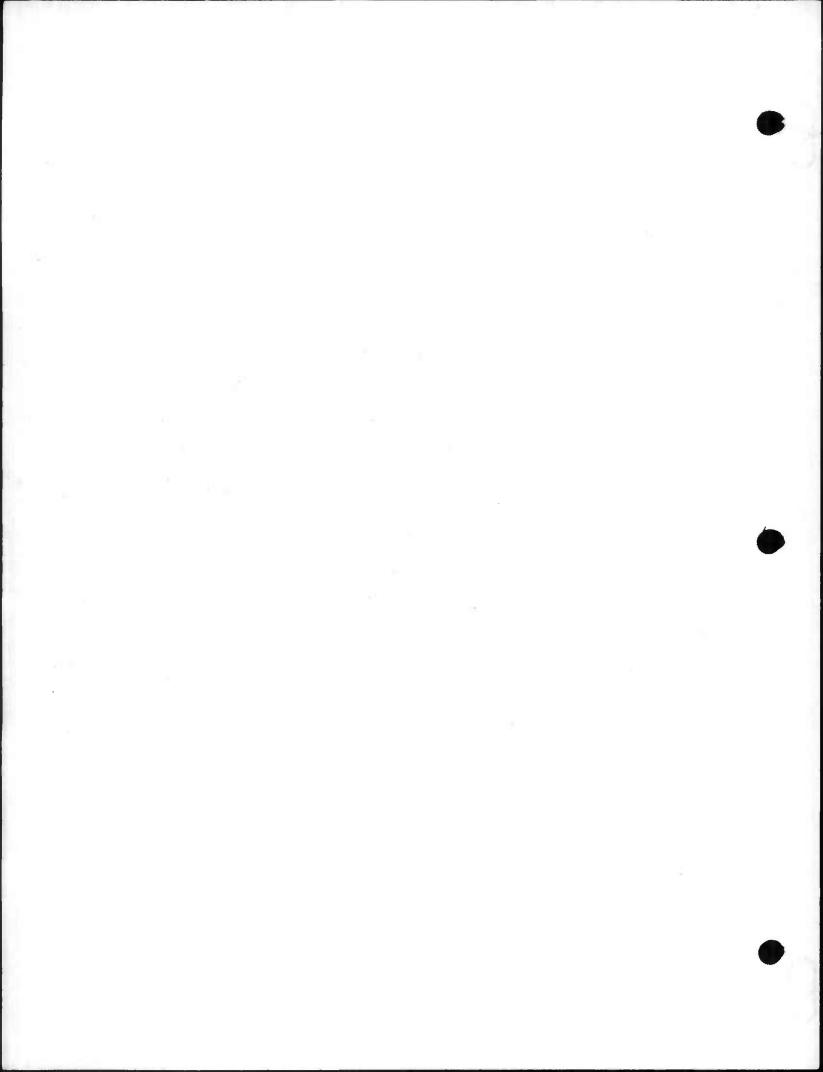
2
MEDICAL EXAMINER: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 08860 m

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KIM Agnes Hospital 900 S. Caton Ave. Baltimor LISA OCT 1 97995

DHMH-16 Bey 1/89



6. BIRTHPLACE (State or Foreign

Maryland

4:40 am "

YEAR

9c. COUNTY OF DEATH

REG. NO

Oct 18 1995

2. DATE OF DEATH

SULLIVAN

5. SEX

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

BYRNES

6. AGE (In yrs. last birthday)

FOR STATE REGISTRAR

ANNE

4. SOCIAL SECURITY NUMBER

1 DECEDENT'S NAME (First Middle Last)

1 -

7. DATE OF BIRTH (Morth, Day, Year) NOV. 18, 1906 IF UNDER I YEAR IF UNDER 24 HRS. MONTHS DAVE HOURS 1 M 2 X F 219-60-8160 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Saint Joseph Medical Center Towson, Maryland DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION N/A Maryland Baltimore City permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 115 E. Melrose Avenue 21212 the burial-transit 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Wildowed 4 Divorced 935 ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 165 KIND OF BUSINESS/INDUSTRY use (Specify only highest ive kind of work done
Do NOT use retired.) for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL detached Homemaker Own Home 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) 2 Ħ Patrick Sullivan Anne BE should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 page 5 s Hon. J. Norris Byrnes 7103 Charles Spring Way, Towson, Maryland 21204 e 20 METHOD OF DISPOSITION
1 Surfal 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must director, Dulanev Valley examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Torre 6500 York Road, Baltimore, Maryland 21212 the in by the medical 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one ceuse on each line. Pilled IMMEDIATE CAUSE (Finel Cremation. other traumatic event, the disease or condition **PNEUMONIA** completely reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if sny, leading to immediate ceuse. Enter UNDERLYING e attending physician ental Hygiene prior tr OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 the atten Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY MEDICAL and by PERFORMED? any Signed the ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 1 TYES 2 NO Shows a CEREBROVASCULAR ACCIDENT Deen H. of B DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate hi tem HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 TYES 2 postlent 2 - ER/Oulpatient 3 - DOA 5 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCUREO marked, 1 Accident 5 Pending ВУ After 28a. PLACE OF INJURY — Al home, larm, street, factory, office building, stc. (Specify) Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be DIRECTOR: A COMPLETED 4 Homicide 200 tem 29a. CERTIFIER 1 THE RTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL (TO THE FUNERAL CE DE filed within 72 he IMPORTANT; If It 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF MERTIFIE 29c. LICENSE NUMBER BE m D 37254 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BOON P LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204
DATE FILEO (Moniti, Day, Year)

OCT 1 91995

July Oliver Parket

Baltimore 10d, INSIDE CITY 1X YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify White Flynn 20c. LOCATION — City or Town, Sieta 10/18 Lutherville, Maryland Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 TYES 2 10

29d. DATE SIGNED (Month, Day, Year)

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COMPLETION OF CAUSE OF DEATH?

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T.	TO THE FUNCTIAN, ORECTOR, After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burist, coercation, or removal.	Ĭ
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FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIE					
1. DECEDENT'S NAME (First, MIASIA, WALTER	Lasti	BAQU		2. DATE OF DEATH	7"1996 "EA"	3. TIME OF DEATH 11:20 am w			
4. SOCIAL SECURITY NUMBER 214-16-7276	1 10 M 2 □ F	7.6 YMS. MC	LINDER 1 YEAR # UNDER 24 HRS. NOTHS DAYS HOURS MIN.	March14	,1919 M	arvland			
Saint Joseph I	Vedical Center	94	Towson, Ma			Baltimore			
HESIDENCE OF DECEDEN	DUNTY	OWN OR LOCATION			10d, IMSIDE CITY				
HERIDINGE OF DECEDER 104. STATE 105.0 Maryland E	altimore		Denis			1 YES 2 XNO			
1812 Main St	reet		101. ZIP CODE 21227			States			
2 □ Widowed 4 □ Divorced	12. WAS DECEDENT EVER FORCES? 1 1 YES IF YES, GIVE WAR OR O	IN U.S. ARMED 2 NO DATES	13. WAS DECEMBENT OF HISP If yes, specify Cuben, Mad 1 (1) YES 2 (XNO Spe	can, Puerto Rican, etc.)	Mia Spe	CE — American Indian, ck, White, atc. city hite			
15. DECEDENT (Specify only highest Elementary/Secondary (0-12) 7 17. FATHER'S NAME (First, Middle, La	EDUCATION	16s. DECEDENT'S US /Give kind of work Ms. Do NOT use of	done during most of working	16b. KIND OF 8	JUSINESS/INDUSTRY	11.4.50.00			
₫ 7		clerk			stingho	use			
				e Bazzel					
Henry Baquol		19b, MAILING AC	DESS Dess De	Market and Administration of the Control of the Con					
Margaret A.			Main Street			land21227			
23. BAST I. Enter the disease shock, or heart fall disease or condition	i, or complications that cause fure. List only one cause on	ed the death. Do not each line.	Memorial 20, MARKE AND ADDRESS OF Ambrose Fu 1328 Sulph enter the mode of dying, si	neral Ho ur Sprin	me, Inc				
resulting in death)	DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events									
PART II. Other significant con	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. PART								
25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOMPITAL:		THER:						
DID TOBACCO USE CO	1 M Injustient 2 □ ER/Out 28s. DATE OF INJURY	280. TIME C			W INJURY OCCURED				
2 Accident S Pending		INJUR	M 1 YES 2 NO						
	ot be building, etc. /Sp	RY — At home, farm, etni ecity)	wl, factory, office	281, LOCATION (Stre City or Rown, Sta	et and Number or Plus (te)	/ Route Number,			
September Country deforms determined to the country of the country	PHYSICIANS to the best of my kno		at the time, date and place, and o in my opinion, death occurred at t			(s) and manner as stated.			
200 BONATURE AND TITLE OF CE	торгия	MA	29c. LICENSE N	40	29d. DATE SIGNI	D (Munth, Dec You)			
o Luvyrnon		190	D32	319	10	17/95			
RAYMOND PLACE	CK, M.D., 3449 W	ILKENS AVE		VID. 21229		•			
OCT 1 91995	Julia Mudder Res	LAK							

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withward hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

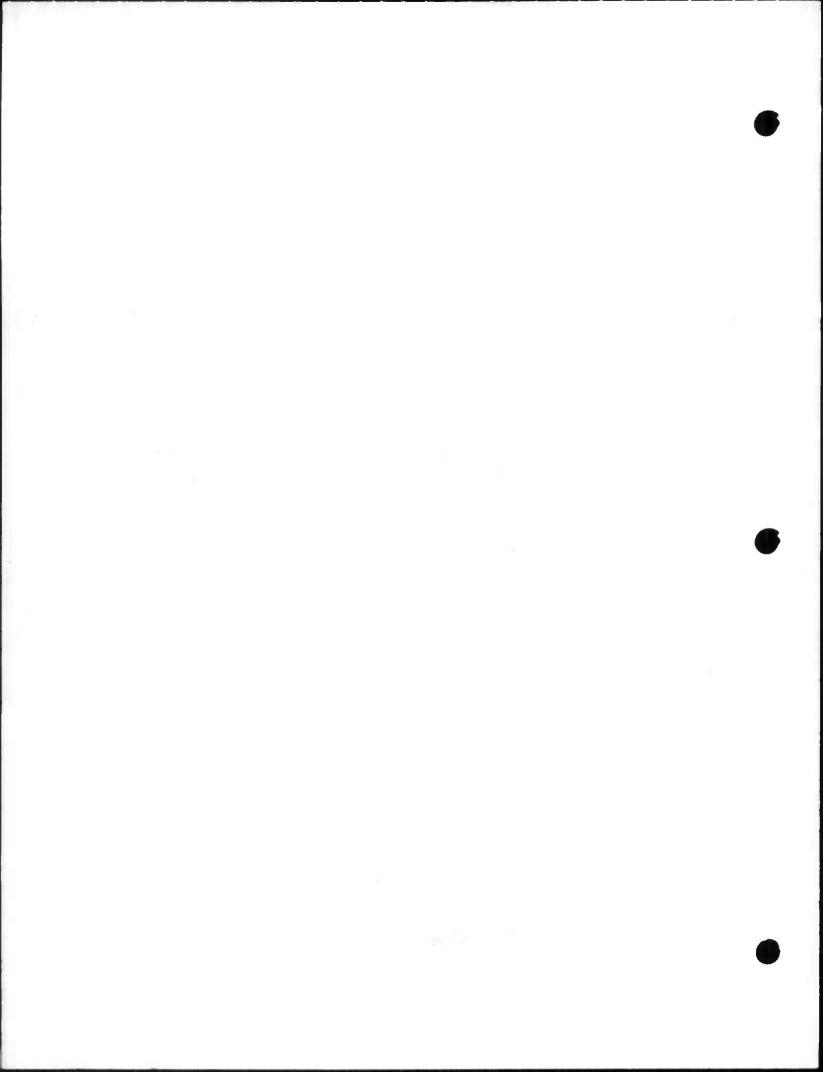
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

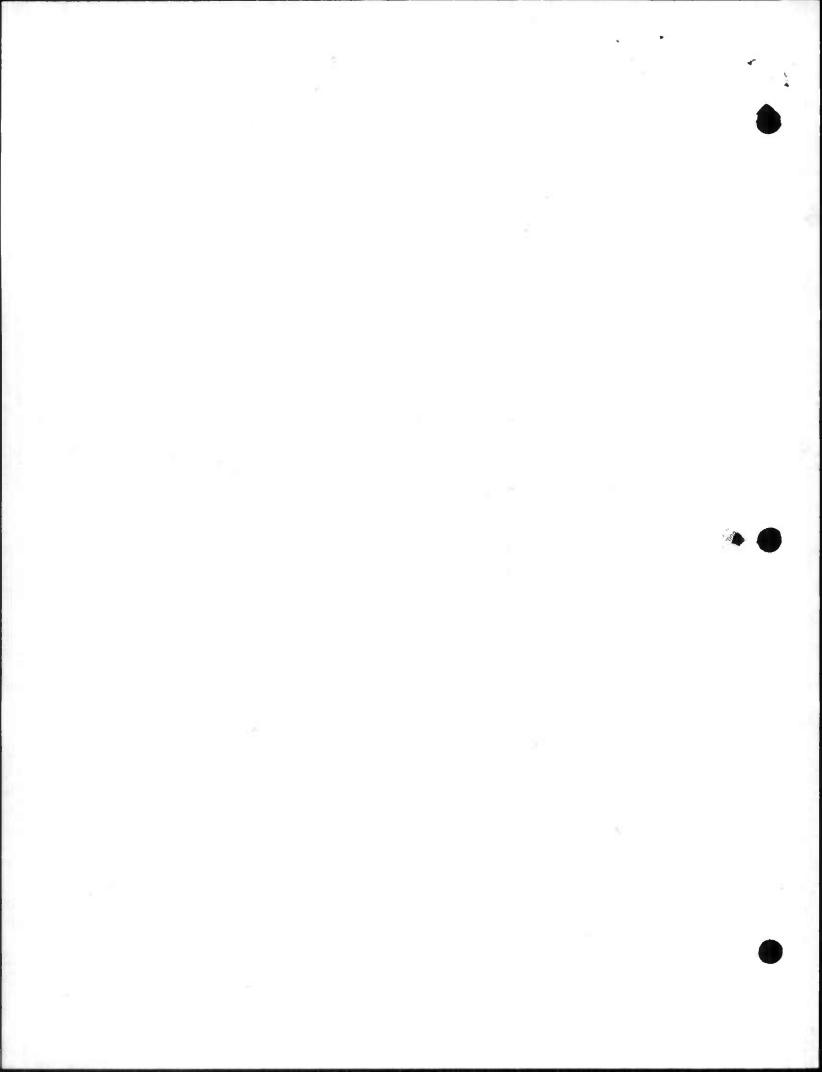
	REGISTRAR	CERTIF	ICATE OF DEATH	REG. NO.	-					
	1. OECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF OEATH				
	Mary E Paniston			MONTH DAY	3 1995	1:15 AM				
	Mary E Banister 4. SOCIAL SECURITY NUMBER 5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	7. DATE OF BIRTH		MPLACE (State or Foreign				
		83 YRS.	MONTHS DAYS HOURS MIN.	AUG. 27,19	12 Count	n/)				
	9e. FACILITY NAME (If not institution, give street end number)	0.5				th Carolina				
œ	se. Process thanks (if not institution, give street and number)		96. CITY, TOWN OR LOCATION OF O	EATN	9c. COUNTY OF D					
ō	HESDENCE OF BECEFAL HOSP		Balto City		N/.	A				
Di C	10a. STATE 10b. COUNTY	10c CIT	Y, TOWN OR LOCATION							
Ē		1.00	The second second			10d. INSIDE CITY LIMITS?				
	Maryland N/A	Ball	timore City			1 XYES 2 NO				
NA.			10f. ZIP CODE		10g. CITIZEN OF Y					
Ē	3825 Beech Avenue		21211		U.	S.A.				
FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1	VER IN U.S. ARMED	13. WAS OECENDENT OF NISPAI If yes, specify Cuben, Mexico	NIC ORIGIN? (Specify Yes	or No- 14. RACE	E — American Indien, k, White, etc.				
BY	1 Never Married 2 Merried IF YES, OIVE WAR	OR DATES	1 VES 2 NO Specif		Speci					
						" White				
E	15. DECEOENT'S EOUCATION (Specify only highest grade completed)	16a. OECEDENT'S (Give kind of v	USUAL OCCUPATION vork done during most of working	16b. KIND OF BUS	NESS/INDUSTRY					
E	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	e retired.)							
MP	12	Homemak	er	Own hor	ne					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Meiden S						
BE (Samuel Stratton Booker		Luci 11	e Guerard	Pollit	zer				
	19. INFORMANT'S NAME (Type/Print)	19b. MAILINO	AOORESS (Street and Number or Rural							
2	Samuel M. Banister	l l	Beech Avenue, Ba			21 21 1				
	200. METNOD OF DISPOSITION		OF DISPOSITION (Name of	DATE 20c LOC	ATION City or To	CICII				
	1 Burlel 2 X Cremation 3 Removal from State 4 Donation 6 Other (Specify)	cemetery cremetory or of		10/19 Balt	imoro l	Maryl and				
	21. SIGNATURE OF FUNERAL BERYJCE LICENSEE	Torcer From	22. NAME AND ADDRESS OF FA	CILITY	more, r	arytand				
	1100		Mitchell-Wie	defeld Home	e. Inc.					
	John May		6500 York Ro	ad Raltim	ore Mary	vland 21212				
	23. PART I. Enter the diseases, or complications that complete shock, or heart fallure. List only one cause	aused the deeth. Do n	ot enter the mode of dying, suc	h aa cerdiac or reapir	atory arrest,	Approximate				
(IMMEDIATE CAUSE (Finei	on each inte.				Interval Between Onset and Daath				
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3	CAUSE (Disease or Injury									
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CERTIFICATION	resulting in death) LAST									
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DICAL	PART II. Other algnifficent conditions contributing to de		1	PERFORM		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
ăl	COPD, HTN, large	2 cell lyn	iphoma of mou	1 YES 2	NO NO	COMPLETION OF CAUSE OF DEATH?				
ME	CAD				`	1 - YES 2 50 NO				
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?									
S	HOSPITAL:	NOutpatient 3 DOA	OTHER: 4 □ Nursing Nome 5 □ Residence	8 (1) Other (Specific)						
<u> </u>	27. MANNER OF OEATN 26e. OATE OF IN.	URY 26b. TIM	E OF 28c, INJURY AT	26d. DESCRIBE NOW IN	JURY OCCURED					
	1 Neturat 5 Pending (Month, Day,	Year) INJ	M 1 YES 2 NO							
B	2 Accident Investigation 3 Suicide Could not be 28e. PLACE OF III	JURY — At home, farm, a		281, LOCATION (Street en	od Number or Dumi E	Pourte Mumber				
	4 Nomicide determined building, etc	(Specify)	,,	City or Town, State)	d Number of Auren	noute Namber,				
<u> </u>	29e. CERTIFIER . W									
를	(Check only 1) CERTIFYING PHYSICIAN: To the best of my									
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of exam	Inetion end/or investigation	n, in my opinion, death occured at the	time, date and place, end	due to the ceuse(e) end manner es stated.				
BE	294 SIGNATURE AND TITLE OF CENTIFIER		29c. LICENSE NUM	MBER	29d. DATE SIGNED	(Month, Day, Year)				
	T- Trunter coollo MD Into	on Dept. of.	Med. UMH AU 4176	435A53063	10/	18/95				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE (OF OEATN (ITEM 27) (Type.	Print)							
	Dr. P. Hunter Spotts-Ir	item Dept.	of Med. UMH	Baltimore	MD 21	218				
	31. DATA PILEO (Month ground g				0 0 17					
- 1	UU 1 4 777 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Manta M								





TO BE COMPLET	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema 1, or removal.
he funeral director, page 5 should be detached for u	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u
ir death. Page 6 may be retained by the hospital or	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, et hours after death. Page 6 may be retained by the hospital or

	1 - FOR STATE (F MARYLA		RTMENT OF I		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN	
	MILDRED VIRGINIA	1	BROWN			OCTOBER 1	AY YEAR 8 1995	1415 M	
-	4. SOCIAL SECURITY NUMBER 1 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YE			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	HPLACE (State or Foreign		
	212 20 2656 77			MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	try)		
	12-08-1917 MA						RYLAND		
DIRECTOR	MONTGOMERY GENERAL RESIDENCE OF DECEDENT			1	OLNEY	EATN	9c. COUNTY OF I	GOMERY	
S	10e. STATE 10b. COUNTY		10c, CI	TY, TOWN OR LOCA	TION			10d. INSIDE CITY	
	MARYLAND HOWARD			CLARKSV				1 YES 2 X NO	
A.					. ZIP CODE		10g. CITIZEN OF		
FUNERAL	HILLTOP HOUSE, 6540 HA			AD	21029		U.S.	Α.	
E	500050	DENT EVER IN U	U.S. ARMED			HC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No — 14. RAC	E — American Indian, ik, White, etc.	
ВУ		VE WAR OR DAT			2 NO Specify		Spec		
					24			WILLE	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	1	(Give kind of	Work done during me	ON ost of working		SINESS/INDUSTRY		
Щ	Elementary/Secondary (0-12) College (1-4	or 5 +)	ille. Do NOT u	ise retired.)		ANNE AR	UNDEL CO	UNTY BOARD	
AP.	12 4		PRINC	IPLE		OF E	DUCATION		
ő	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)		
ПС	OSCAR ASA		LUM		MARY	ELIZABETH		SUMMERS	
00	19a, INFORMANT'S NAME (Type/Print)			Anneses /com		Route Number, City or Tow	o Conta Tir Conta		
2	VAUGHN H. DULLABAUM					HAGERSTOW		AND 21740	
	204, METHOD OF DISPOSITION								
	1 - Buriel 2 - Cremetion 3 - Removal from State		PLACE AND DATE tery, crematory or	OF DISPOSITION (No	ime of	10/23 20c. LO	CATION — City or To	own, Steta	
- 1	4 Donation 5 Other (Specify)			N MEMORI	AL PARK	1005 GL	EN BURNI	E, MARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1 1		22. NAME A	D ADDRESS OF FA	CILITY SINGLET	ON FUNER	AL HOME,	
	1 K Lhen &	1.6.	~	1 250	OND AVENU BURNIE, I	UE, D.W.	21061		
	23. PART I. Enter the diseases or complications	that caused t	the death Do						
	ahock, or heart fellura. List only one	ceuse on aec	h ilne.	not enter the mo	de of dying, suci	n as cerdiec or reap	ratory arrest,	Approximata Interval Batween	
	IMMEDIATE CAUSE (Final disease or condition	25 4		20				Onset and Death	
	resulting in death)	SPIRA	iory	FAILURE				SAMS	
	141			**					
Z	Sequentially list conditions, b. D.	WAL	FAW CONSEQUENCE OF	li					
CERTIFICATION	il any, leading to immediate								
2	CAUSE (Disease or Injury	2445	FMU	sec					
E	that initiated events	TO (OR AS A C	AS A CONSEQUENCE OF):						
띪	resulting in death) LAST	SIZUR	vri						
	DAGT II Other al- III - A - III	30 ===							
MEDICAL	PART II. Other algnificant conditions contributing	g to death but	not reaulting	in the underlyin	g ceuse given in	Part I. 24e. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
음						1 TYES 2	000	COMPLETION OF CAUSE OF DEATH?	
W								1 YES 2 NO	
	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF	DEATH Y	ES NO F	UNCERTAIN	<u>ч</u> П	1		
M	25. WAS CASE REFERRED TO MEDICAL			TN (Check only one)					
Sic	EXAMINER?	2 ER/Outpati	ient 3 🗆 nos	OTHER:	a E D Build	8 T Out (0 "			
PHYSICIAN:	27 MASSATA OF DEATH 28e. DAT	E OF INJURY	28b. Til		e 5 Residence	28d. DESCRIBE NOW II	N.IIJRY OCCUPED		
	Natural 5 Pending (Mo	th, Day, Year)		JURY WO	RK?	LUG. DEGUNIDE NOW II	TOUR OCCURED		
BY	2 Mccident Investigation	CE OE IN HIM	At home of		rES 2 NO				
	3 Suicide 8 Could not be built	ling, atc. (Specify,	at nome, farm,	atrest, factory, offic	.	281. LOCATION (Street e City or Town, State)	and Number or Rural i	Route Number,	
	. Wester Silliston								
7	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the be	st of my knowled	dge, death occur	ed at the time, date	and place, and due	to the cause(a) and mar	iner as stated.		
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis							i) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER								
BE	1.000 00				29c. LICENSE NUM		29d. DATE SIGNED	. /	
2	30 NAME AND ADDRESS OF SERVICE AND ADDRESS OF		11 APP		04501	4	October	12/1995	
	_					0.	ha .	2.005	
- 11	JO. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ISABELLA MARTIRE NO OLIMOWOOD COVET #111 OLIMY NO 20832								
il.		TRAR'S SIGNAT							



1	٠	STATE REGISTRAR
_	_	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICATE OF	DEATH	REG. NO	D.					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME	OF DEATH			
		Elizabeth	H. Br	rown		OCT 17	, 1995	9:	00 a	М		
	4. SOCIAL SECURITY NUMBER 216-20-4660	5. SEX 6. AGE	(In yrs. last birthday 9 YRS.		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUNE 20,	0.1	BIRTHPLACE (SI				
OR	99. FACILITY NAME (If not institution, give a 312 Long Cove Land			96. CITY, TOWN	Baltin	OF DEATH	аща	Ī				
딥	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT	Y	100.0	TY, TOWN OR LOCA	TION							
L DIRECTOR	Maryland Balti	more			Essex		1 TYES	IDE CITY ITS?				
FUNERAL	312 Long Cove Lan	ie		1	21221		10g. CITIZEN	OF WHAT COU	INTRY?			
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	If yes, s		NIC ORIGIN? (Specify Yon, Puerto Ricen, atc.) y:	ee or No- 14.	RACE — Americ Black, White, e	ite			
	15. DECEDENT'S EDU	CATION		'S USUAL OCCUPAT		16b. KIND OF 8	USINESS/INDUST			_		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4 or 5+)	Homemak	· ·	ost of working	Own	Home					
COM	17. FATHER'S NAME (First, Middle, Last) John Haferk	amp.				ME (First, Middle, Meide						
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street		Louise Gre	0	de)		_		
2	Charles J. E. Bro		2 Woo	ody Road	Essex,	MD 21221						
i	20e. METHOD OF DISPOSITION 1	Me Me	BLEO" CE	eof disposition (A	Inc. 10/1		timore					
	21. SIGNATURE OF SUNERAL SERVICE LI		K	crema	NO AODRESS OF FA	ety of Ma	ryland,	Inc.				
	George E. Mach			299 F	rederick	Rd. Balti	more, M	D 21228	8			
	23. PART i. Enter the diseasea, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cards on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentisily list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
		σ										
EDICAL	PART II. Other algolificant condition	is contributing to death	but not rasulting	in the underlying	ig causa given in		RMED?		E PRIOR TO			
×	DID TOBACCO USE CONTI	RIBLITE TO CALISE (DE DEATH Y	YES - NO I	T LINICEDTAIL			1 YES	3 2 NO			
M	25. WAS CASE REFERRED TO MEDICAL	RIBOTE TO CAUSE (ATH (Check only one		<u> </u>						
Sic	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out	Instinct 3 DOA	OTHER:	ne 5 Residence	2 T 24 T 2				-		
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TI	ME OF 28c. IN	JURY AT	28d. DESCRIBE HOW	INJURY OCCURE	ED		-		
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	10	M 1	ORK? YES 2 NO							
	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, term, scify)	, street, factory, offi	20	281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of my know	wledge, death occur	rred at the time, dat	e end place, end due	to the cause(s) end me	nner es stated.			_		
O		R: On the basis of exemination						use(s) and man	ner es stated.			
BEC	296. SIGNATURE AND TITLE OF CERTIFIER	3 .4 .0 //			29c. LICENSE NUI	MBER	29d. DATE SIG	GNED (Month, De	ay, Year)	_		
	un. wy	4 Kenica			D19	714	▶ oc		1995			
2	30. NAME AND ADDRESS OF PERSON WHO Michael J. Pur	ctell, M.D										
	31. DATE FILED (Month, Day, Year)	22 REGISTRAR'S SIGN	NATURE	Dasteri	1 Avenue	e palti	more,	MD ZI	224	_		
	OCT 1 91995 AM	in Maudean Real	4.4									

TO THE MOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020



CERTIFICATE OF DEATH

29c. LICENSE NUMBER

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

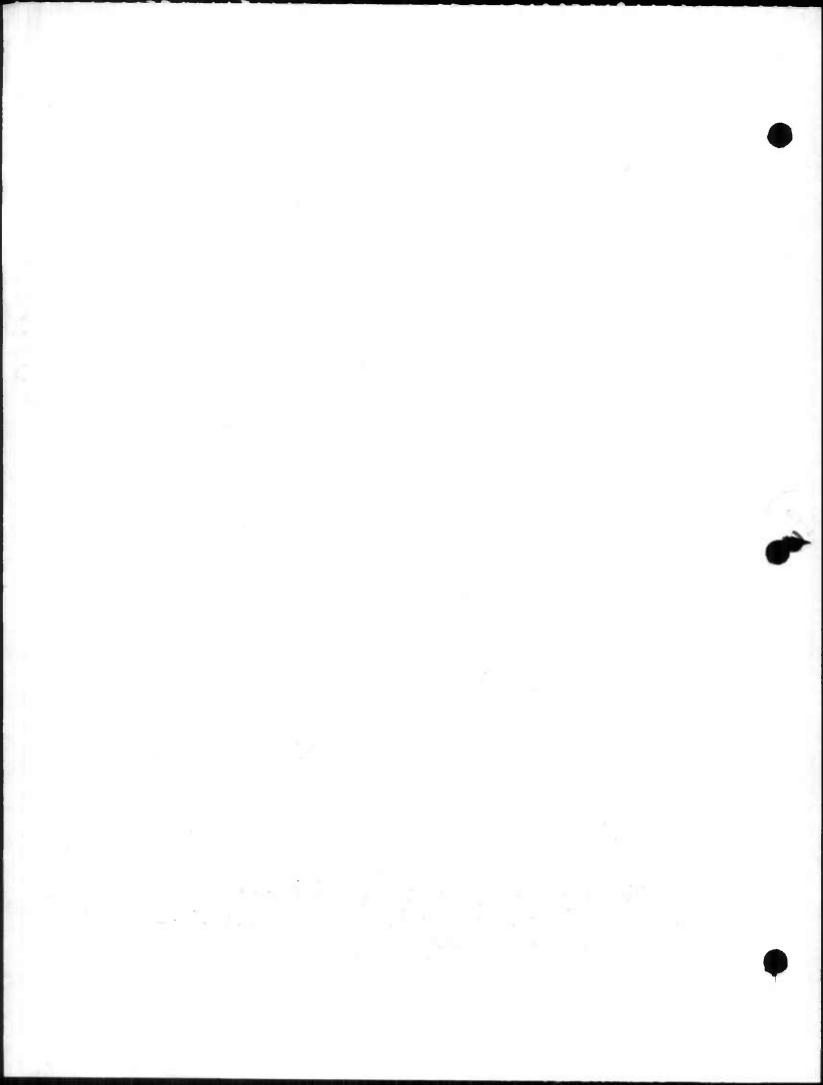
NRYLAND 21215-0020	ned by the hospital or attending physic	ould be detached for use as the burial-		Ted at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	the death certificate be executed within 24 mills and the hage 6 may be retain.	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the burial-	I METTAI PYGIETE DITOL TO DUTIAL, CTETTAINOT, OF TETTUVAL.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that t	TO THE FUNERAL DIRECTOR: After this certificate has been signed by	be filed within 72 hours after death with the State Dept. of nearth and Mehtar hyghere prior to build, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any i

BE 2

Joseph Nathaniel Burnette, Sr. October | 4. SOCIAL SECURITY NUMBE 217-09-8101 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 75 YRS. Feb 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 322 West Bruce Street Baltimore Pages 1, 2, RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10a. STATE Baltimore Maryland n/a permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE burial-transit 21223 322 West Bruce Street 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 1 Never Married 2 X Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced as the COMPLETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highe Ď Elementary/Secondary (0-12) College (1-4 or 5+) 5th Grade detached Auto Mechanic once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Elmer Burnette Florence Gross BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1105 Poplar Grove Delores Owens 90 20b. PLACE AND DATE OF DISPOSITION (Name of Oct must oudon Park Cemetery 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 medical 23. PART /. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel 9 disease or condition and completely fi burial, cremation YS/VOVO resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF 15 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending phy Mental Hygiene (or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL and any signed Heafth a shows ? DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 s 28. PLACE OF DEATH (Check only one) certificate h. in the State D. or Item 2 25. WAS CASE REFERRED TO MEDICAL 1 YES 2 NO HOSPITAL Inpatient 2 ER/Oulpatient 3 DOA 4 Nursing Home 5 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 27. MANNER OF DEATH 28c, INJURY AT marked, this c 1 Natural 2 Accident 1 YES 2 NO ВY After 1 death 28a. PLACE OF INJURY — At home, farm, street, lectory, office building, etc. (Specify) 40 3 Suicide COMPLETED 8 Could not be DIRECTOR: / hours after of item 28 is 4 Homicide datarmined 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and place, and due to the cause(s) and manner as stated. FUNERAL within 72 I = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated

34398 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 3. TIME OF DEATH 2. DATE OF DEATH MONTH 13, 1995 5:40 PM 7, 1920 Maryland 9c, COUNTY OF DEATH n/a 10d. INSIDE CITY t YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: **Black** 16b. KIND OF BUSINESS/INDUBTRY Anderson Chevrolet Baltimore, Maryland 21216 20c. LOCATION — City or Town, State 19 Baltimore, Maryland 22. NAME AND ADORESS OF FACILITY Nutter Funeral Homes, Inc Approximata interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TYES 2 T NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d, DATE BIGNED (Month, De



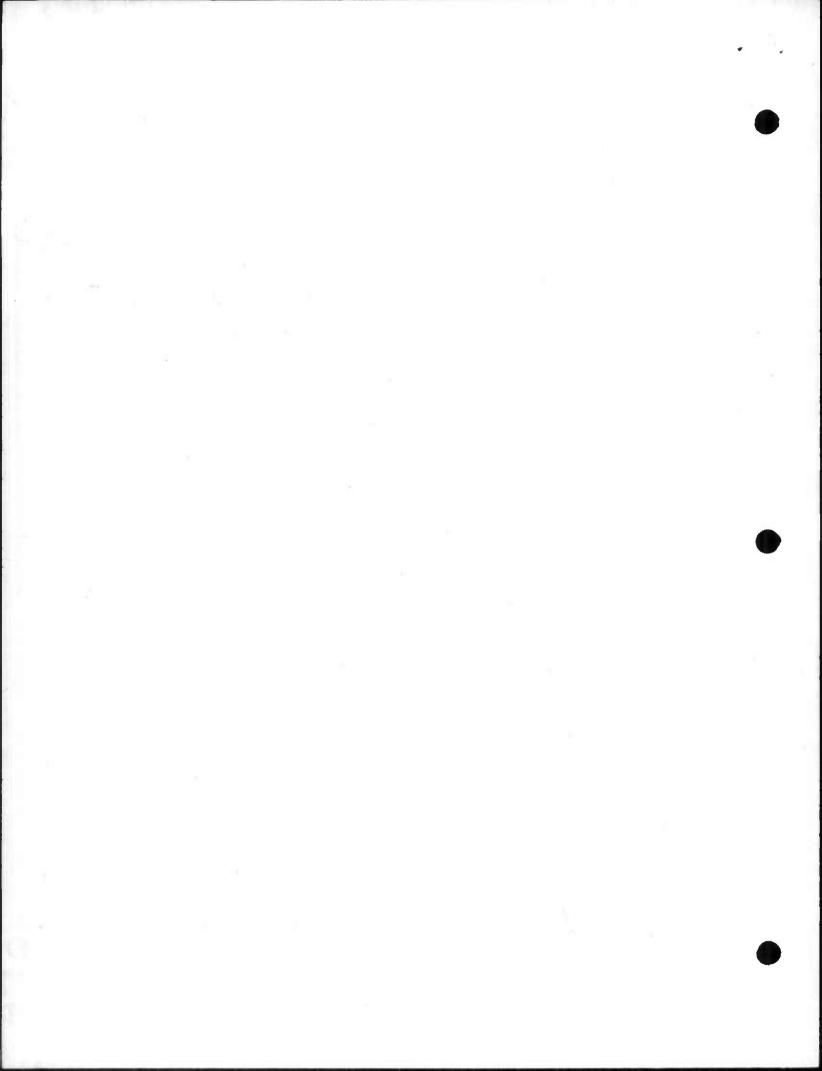
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed without clean. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

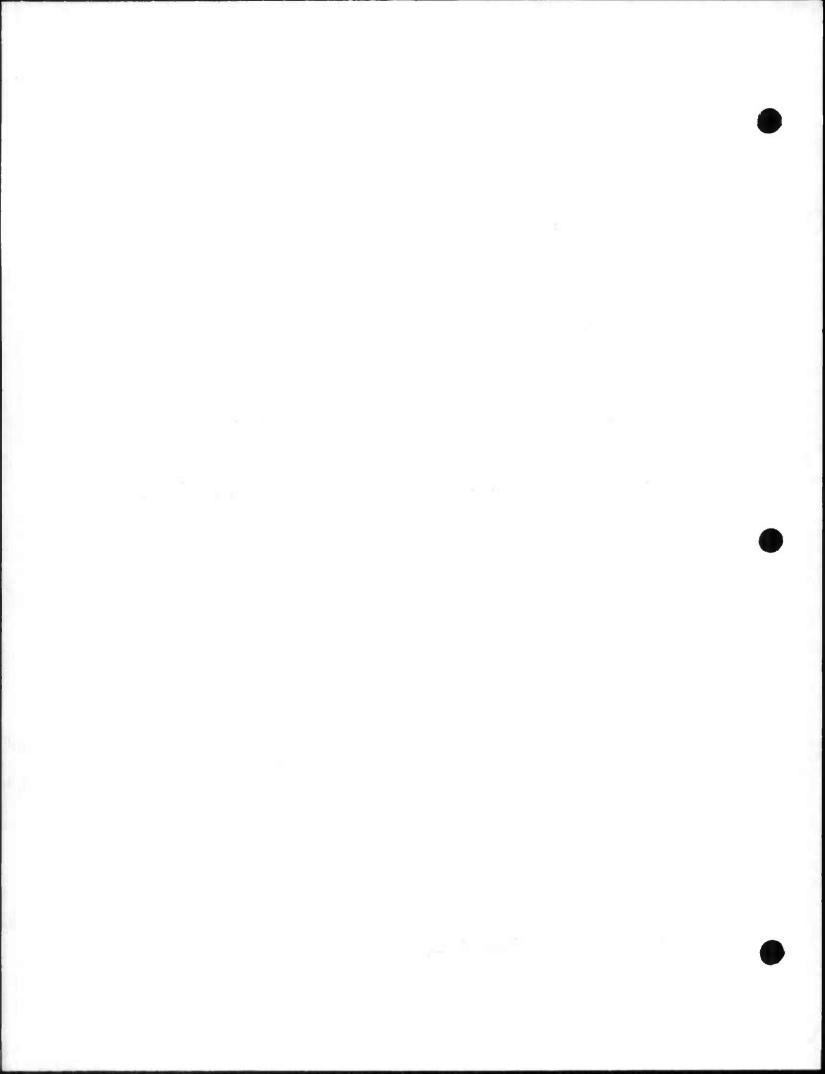
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		IT OF HEALTH AND	MENTAL HYGIE								
	1. DECEDENT'S NAME (First, Middle, Last)	F. BUTL	r 0		2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AGE (Ja.yrs.		ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	13 199.	BIRTHPLACE (State or Foreign						
	011100	□M2×F 8	YRS. MONTH	DAYS HOURS MIN.	Sept 13		Country) N.C.						
TOR	9a. FACILITY NAME (If not inatitution, give atreet GONES RESIDENCE OF DECEDENT	2 tospita	9b. Cf	Da to	EATH	9c. COUNTY	OF DEATH NIA						
DIRECTOR	10a, STATE 10b, COUNTY	A	10c. CHTY, TOWN	OR LOCATION		10d, INSIDE CITY LIMITS? 1 YES 2 NO							
FUNERAL	2417 Terra	Firma	Rd	101, ZIP CODE	25	10g. CITIZEN	OF WHAT COUNTRY?						
BY FUR	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IN IF YES, GIVE WAR OR DATES	ARMED 1:	I. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxico 1 YES 2 NO Specifi	an, Puerto Rican, etc.)	Yes or No 14.	RACE - American Indian, Black, Whita, atc. Specify: Black						
Œ	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Size kind of work done during most of working life to help to the life of help to the l												
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use retired	ewife	n	ever-	worked						
E CO	17, FATHER'S NAME (First, Middle, Lest)	Toxworth	Ja	18 MOTHER'S NA	AME (First, Middle, Malo	len Surname)	lis						
TO B	INFORMANT'S NAME (Type/Print)	lac	196. MAILING ADDRE	SS (Street and Number or Rural	10.		7						
	20e METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Removal	I from State 200 PLAC	CE AND DATE OF DISPO	al The (1		LOCATION - CHY							
	Conation 5 □ Other (Specify) 21. SIGNATURE OF SUNERAL SERVICE LICENS	-	a 1107	MAI I I'M THE	CILITY 45	aure	ind						
	· Mash J	Hurr	Y	Harch F.	th-wes bash	Ave							
	23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause Dn each line. IMMEDIATE CAUSE (Final												
	immediate cause (Final disease or condition resulting in death) Doe to (or as a consequence of):												
-	Doe to (or as a consequence of): - diabetic newwordth												
TIO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	SEQUENCE OF):	1									
FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	(MODEM) DUE TO (OR AS A CONS	SEOUENCE OF):				5 years						
CERTIFICATION	resulting in death) LAST												
7	PART II. Other significant conditions c	ontributing to deeth but no	t resulting in the u	enderlying ceuse given in	Part I. 24a. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS						
MEDIC					1 _ YES	2 NO	COMPLETION OF CAUSE DF DEATH?						
W.	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF DE	ATH YES	NO UNCERTAI	N D		1 TES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PL	ACE OF DEATH (Chec	k only one)									
IYSI		OSFITAL: Sinpetient 2 ER/Outpetient		reing Home 5 - Realdence									
Y PH	1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HON	V INJURY OCCURE	ED						
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At building, atc. (Specify)	et and Number or R	tural Route Number,									
COMPLETED		N: To the best of my knowledge,					use(a) and menner as stated.						
BE	296. SIGNATURE AND TITLE OF CERTIFIER	wrany, M	. 0.	29c. LICENSE NUI	MBER	29d. DATE SIG	GNED (Month, Day, Year)						
2	30. NAME AND ADDRESS OF PERSON WHO CO	CA	TEM 27) (Type, Print)	Cat	4.1	\$ 0	13 1995						
	31. OCT 1 1995	32 DEGISTRAR'S CHAPURE		- alu	s are	alu	7,- 10						



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Mic	iddle, Last)								2. DATE OF DEATH	,.		. TIME OF DEATH
		George (Cleve	land Bur	gan,	Jr.					Oct. 18,	~ 1995	YEAR	04:15 A M
		4. SOCIAL SECURITY NUMBER		5. \$EX	6. AGE (In	yrs. last birthda			IF UNDER		7. DATE OF BIRTH (Month, Day, Year)			ACE (State or Foreign
2		212 03 5389		12℃KM 2 □ F	7 9) YRS	MONTHS	DAYS	HOURS	MIN.	July 30,	1916		
pinous	~	9e. FACILITY NAME (If not institu					9b. CIT	, TOWN	OR LOCATIO	ON OF DE	ATH	9c. COU	INTY OF DEA	тн
2,	CTOR	Carroll Count	ty Ge	neral Ho	spita	1	We	stmi	inster	<u> </u>		C	arrol1	1
Pages 1.	E C	10a. STATE 10	b. COUNTY			10c.	ATY, TOWN	OR LOCA	ATION				10	Od. INSIDE CITY
2	DIRE	Md.	Carr	011			West	nins	ster					LIMITS?
permit.	AL	10e. STREET AND NUMBER						10	of. ZIP CODE	E		10g. CIT	IZEN OF WH	AT COUNTRY?
150	FUNERAL	445 P1	easan	ton Road				2	21157			I	U.S.A.	
DZO physician. burial-transit	5	11. MARITAL STATUS 1 Never Married 2 X Mar	mlad	12. WAS DECEDEN FORCES? 1	T EVER IN U	S. ARMED	13.	WAS DE	CENDENT O	F HISPAN	IIC ORIGIN? (Specify Yan, Puerto Rican, etc.)	s or No-	14. RACE -	- American Indian, White, atc.
5 9 9	B≺	3 Widowed 4 Divorced		IF YES, GIVE V					S 2X NO			- 3	Specify:	
attendir	ED	15. DECEDE			10	6e. DECEDEN	'S USUAL C	CCUPAT	ION		16b. KIND OF BU	ISINESS/INC	White	3
212 al or att for use	П	(Specify only hig Elementary/Secondary (0-12)		College (1-4 or 5		(Give kind	of work done use retired.)	during m	nost of worldn	g		OIILEOOAIILE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
14	COMPL	12		_		P1um1	er					onst	ructio	on
the hospit detached	Ö	17. FATHER'S NAME (First, Middle	e, Last)						18. MOTH	HER'S NAI	ME (First, Middle, Malder	Surname)		
# 8 E	BE	George Burga		r.					El	lsie	Lipper			
retained by 5 should by notified a	2	19a. INFORMANT'S NAME (Type/									Route Number, City or Tox			
(1) as		Helen Florence								Wes	stminster,			
. Page 6 may by ral director, page		20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 4 Donation 5 Other (Sp.		oval from State	20b. PI cemete	ary, crematory	E OF DISPO	SITION (A	Name of		10/23/95	CATION —	City or Town	, State
tuneral director.		21. SIGNATURE OF FUNERAL SE		ENSEE	_ [Car	TOIL (rema	NAME A	AND ADDRES	71CE	10/53/32	натря	stead,	Md.
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784												
2 9 2 9	\vdash	HIMMY	711.	Hough	T_			2.0.	Box 1	.95	Sykesville	, Md	. 2178	34
hours after to the by the or remove medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only give cause on each line.												
전 등 등 기계 등 기계 등 기계 등 기계 등 기계 등 기계 등 기계 등		IMMEDIATE CAUSE (Finel												
ted within 24 in completely fille ial, cremation, event, the		resulting In death)	•	DHE TO		ONSEQUENCE								8 hrs
8 8 - 5	_		_	DOE 10	(On AS A C	ONSECUENCE	OF):							1
	CATION	Sequentially list conditions if any, leading to immediat		OUE TO	(OR AS A CO	ONSEQUENCE	OF):							1
ficate be physician ne prior to be traur	3	cause. Enter UNDERLYING CAUSE (Disease or injury												
	RTIF	that initiated events resulting in death) LAST		DUE TO	(OR AS A CO	ONSEQUENCE	OF):							
F 5 - 0	EH	Total III does in Color		i										-
The the		PART II. Other algnificent of	condition	contributing to	death but	not resultin	g in the u	deriyir	ng cause g	Iven In	Pert I. 24s. WAS AN			ERE AUTOPSY FINDINGS
that that	DICAL	Cereb.	-/	Vasa~	he	Ac	cid.	en ?	+		PERFO		00	MILABLE PRIOR TO OMPLETION OF CAUSE
requires thaten signed of Health a	ME													F DEATH?
has been Dept. of		DID TOBACCO USE	CONT	RIBUTE TO CA	USE OF	DEATH	YES 🗆	NO E	UNC	ERTAIN	10			
- a a a	SICIAN:	25. WAS CASE REFERRED TO MI EXAMINER?	EDICAL	HOSPITAL:	28.	PLACE OF D	OTHE)					
SICIAN: The certificate the State	YSI	1 TYES 2 NO		1 Inpatiant 2		ent 3 🗆 DOA			me 5 🗆 Re	sidence	8 Other (Specify)			
PHYSICIAN: this certifica with the St	PHY	27. MANNER OF DEATH 1 ☑ Natural 5 ☐ Pend	ding	28a. DATE OF (Month, D		28b. 1	IME OF NJURY	W	JURY AT ORK?		28d. DESCRIBE HOW	INJURY OCC	CURED	
	2 Accident Investigation								YES 2	NO	201 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1.00		
TTEN TOR:	ee W 4 Homicide determined building, etc. (Specify)							ory, one	Cu		26f. LOCATION (Street City or Town, State)	and Number	or Hunti Hout	w Number,
DIRECT POUR TOWN	COMPLET	29a. CERTIFIER	INO PHYSIC	TAN: To the heat of	eme benevia de					(0)				
別 単元 =	MP										to the cause(s) and ma time, data and place, ar			nd manner se stated
FUN WITH		29b. SIGNATURE AND TITLE OF							29c. LICE			_		
TO THE HOSPI TO THE FUNER De filed within	BE	Roll	1.	Mon,	Ms				1000		PRL	296, DATE	E SIGNED UM	P 9 T
FFAS	7	30. NAME AND ADDRESS OF PE	RSON WHO				oe, Print)	_			9		- / /	7
5		Robert	6.	Moss	, MD	/	14 1	Pus	11985	(enter Li	1. K	Painte	itoma, Md
		31. DATE FILED (Month, Day, Year)		32. REGISTRA	R'S SIGNATU	JRE								136
		OCT 1 9 1995) Ja	4 develop	rien	1							41	136



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR		STATE OF N	MARYLAND /				EALTH DEAT		MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First		FRANK	BUZG	ZGIERSKI						OF DEATH	MY	YEAR	3. TIME OF DE		
	4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yrs. las		IF UNDER	1 YEAR	IF UNDER	24 HRS.	OCT	. 15 OF BIRTH	, 19	995	1510	PM	
	219-32-8523		1 📉 M 2 🗆 F	60	YRS.	MONTHS	DAYS	HOURS	BRIM	(Monti	1 30 1	935	Countr	Maryl		
_	9e. FACILITY NAME (If not in					9b. CITY	TOWN O	R LOCATIO		-		-	NTY OF D			
TOR	1507 DELV		VENUE	/ENUE DUNDALK							BALTIMOF					
DIRECTOR	10e. STATE	10b. COUNT				Y, TOWN (ION						10d. INSIDE CI	ТҮ	
	Maryland 100. STREET AND NUMBER	Balti	more			unda.								1 TYES 2X		
FUNERAL	Delvale						101	2122					U.S.A	WHAT COUNTRY		
UNE	11. MARITAL STATUS			T EVER IN U.S. AR							17 (Specify Ye		14. RACI	E — American In	dien,	
1 Never Merried 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican 1 YES, GIVE WAR OR DATES If yes, specify Cuben, Mexicen, Puerto Rican 1 YES 2 NO Specify:										Rican, etc.)		Spec	k, White, atc. White			
ET	(Specify onli Elementary/Secondary (I	ly highest grade 0-12)	College (1-4 or 5	-			during mo	st of workin	g		Const	-wat	ion			
COMPLETED	12		NA	Bri	ck L	ayer							1011			
BE CO	17. FATHER'S NAME (First, N Steven		Bu	ızgiersk				Vic	ctor	ia	Middle, Melder			bulski		
TO	190. INFORMANT'S NAME (Type/Print) B rown		7	24 5	l'st	Street •	eet I	or Rural I	alk,	ber, City or To Mary	en, State, Zi Land	2122	4		
	20a, METHOD OF DISPOSIT 1 Burlel 2 Cremetle 4 Donetton 8 Other	on 3 🗆 Ram	oval from State	20b. PLACE I	matory or r	ther placel			Oct	Ober		ocation –		own, State aryland		
	21. SIGNATURE OF FURERA		COMES 1	Pacie		22.	NAME AN	D ADDRES	S OF FA	CILITY						
	1/1/05	h (P.C Ko	mers	k-						jnacki Balto					
	23. PART I. Enter the dishock, or h	liseeaaa, or leart fellure.	complications the	caused the de	e deeth. Do not enter the mode of dving, such					Ave. Balto., Md. 2				Approxi	mate Batwean	
	IMMEDIATE CAUSE (Fill disease or condition														nd Dasth	
	resulting in death)	→	Arteri	OSCLET			irdi	ovas	scu.	Lar	Disea	ase				
z	_		b.													
VIIO	Sequentially list condition if any, leading to imme	diete	DUE TO	(OR AS A CONSE	DUENCE O	PF):										
CERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or inju- that initieted events		c	(OR AS A CONSE	DUENCE C	F):										
E	resulting in death) LAS	т	d													
	PART il. Other significa	ant condition	ns contributing to	death but not i	resulting	In the u	nderlyln	Ceuse (lven In	Part i.	24a. WAS A	N AUTOPSY	248	b. WERE AUTOPSY	FINDINGS	
CA											PERFO	RMED?		AMAILABLE PRIC COMPLETION O OF DEATH?		
MEC											INSP		NC	1 YES 2) NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? LYYES 2 NO 10 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Nome 3 1/4 residence 8 Other (Specify)																
НХ	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TII	AE OF	28c. INJ	URY AT	sidence		SCRIBE NOW	INJURY O	CURED			
ВУ Р	XX Natural 5 2 Accident	Pending Investigation	(Month, L	zay, rear)	IN	JURY		RK? YES 2	NO							
COMPLETED	3 Sulcide 6 4 Homicide	Could not be determined	28e. PLACE (building	OF INJURY At he atc. (Specify)	ome, term,	street, fed	tory, offic	•			CATION (Street or Town, Steh		or Rural	Route Number,		
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end menner ee stated.															
OM		DICAL EXAMIN	ER: On the basis of e	exemination and/or	Investigati	on, in my	opinion, c	leath occur	red at the	time, date	e and place, e	end due to	the ceuse(e) end menner e	e ateted.	
BE C	296. BIGNATURE AND TITLE	E OF CENTIFIE					***	29c. LICI						1 6 1 0		
10	30. NAME AND ADDRESS OF	E BESTON W	NO COMPLETED CAU	PE OF BEATU ATE	14 on (T-	- 0-1-0		0.0	C.M	. E		10	CT.	16,19	90	

31. DALE HEDING 9 1995 Jale 32 BEGISTRAR'S MAJURE

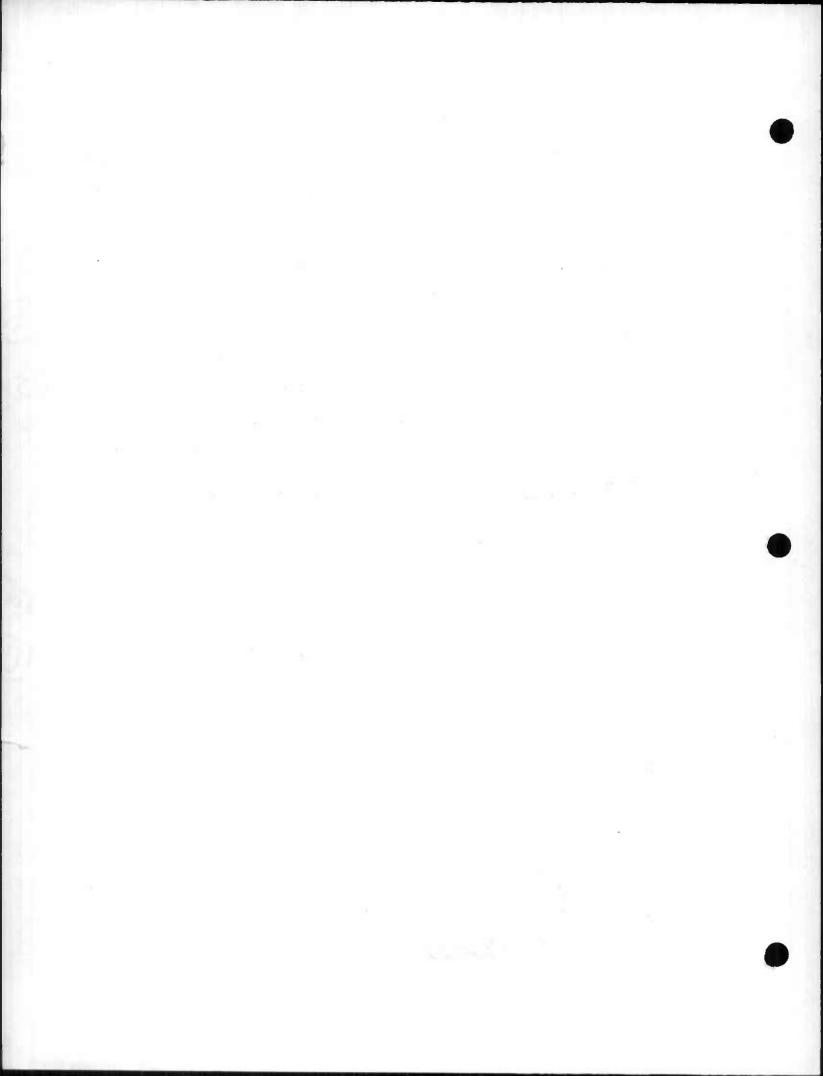
Ann Dikon M.D. 111 Penn Street,

Baltimore, Maryland 21201

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HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

1 - STATE REGISTRAR	STATE OF MARYL		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	_						
1. DECEDENT'S NAME (First, Middle, Last)	EVELYNG.	CHILDER	25	2. DATE OF DEATH DATE OCTUBER		3. TIME OF DEATH S: 45 M					
	5 SEY & AGE /	ryrs. lest birthday) # UN YRS. MONTH	DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Well) MARCH 4, 1	1924 MA						
99. FACILITY NAME (If not institution, give str UNIVERSITY OF MD IT RESIDENCE OF DECEDENT			TIMORE	PEATH	120 110	OUNTY OF DEATH BALTIMORE CITY					
10e. STATE 10b. COUNTY	ARUNDEL	SEVERN	N OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO					
104. STREET AND NUMBER			101. ZIP CODE			OF WHAT COUNTRY?					
1435 EVERGREEN RD	12. WAS DECEDENT EVER IN	II.S. ARMED	21144 13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Ver		STATES RACE — American Indian,					
1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	2 X NO	It yes, specify Cuban, Mexic 1 — YES 2 X NO Speci	an, Puerto Rican, etc.)		Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	Ille. Do NOT use retire	one during most of working	16b. KIND OF BU		₩					
12 17. FATHER'S NAME (First, Middle, Last) JAMES JORDEN		HOMEMAKER		OWN HOI AME (First, Middle, Melden A CLARK							
190. INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Rural	I Route Number, City or Tow							
CHERYL L. WADE			ERGREEN RD., POSITION (Name of OCT.								
Reurial 2 Cremetion 3 Removal from State Cometery, crematory or other place) GLEN HAVEN MEM. PK., 1995 GLEN BURNIE, MARYLAND 22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST Interval Between Onast and Daeth ACCRUBAT INDIVITION DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other algnificant condition				PERFO	RMED?	24b. WERE AUTOPSY FINDING MARILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	26. PLACE OF DEATH (CA		IN 🗆							
EXAMINER?	HOSPITAL:		HER: Nursing Home 5 - Residence	6 Other (Specify)							
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident investigation	28a, DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	ED .					
3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spe-	— At home, farm, street, cffy)	tactory, offica	281. LOCATION (Street City or Town, State	lurel Route Number,						
CONSULT UNITY			the time, data and place, and do my opinion, death occured at th			suse(a) and manner as stated.					
206. SIGNATURE AND THILE OF CERTIFIER		GNED (Month, Day, Year)									
30. NAME AND ADDRESS OF PERSON WH				7301 Consum 16, 1495							
22 GROSN		171101-8	Mn.								
31. DATE FILED (Month, Day, Year) OCT 1 91995	32. REGISTRAR'S SIGN										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

E HANDTHAIN OF MYSICIAN. The law remains that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	E FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	d within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	ATANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law	Ē	be filed within 72 hours after death with the State Dept	IMPORTANT: If item 28 is marked, or item 23

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTAL HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	SHERMAN I	CHOMAS CO	DATES			OCT.13,	1995 T	4:45 P.M.				
		200	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUL. 20.	8. BIRTHPLACE (State or Foreit Country) MARYLAND					
E	90. FACILITY NAME (If not institution, give street NONASTE	end number) Y AVENUE			IMORE		9c. COUNTY	OF DEATH				
6 1	RESIDENCE OF DECEDENT											
DIRECTOR	MARYLAND 10b. COUNTY	N/A		TOWN OR LOCA BALTIM				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	3 N. MONASTER	RY AVENUE		10	1. ZIP CODE 2122	9	100	of what country? 5. OF A.				
BY FUN	11. MARITAL STATUS 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED 2 INO ATES	if yes, so		NC ORIGIN? (Specify Yen, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: BLACK				
旦	15. DECEDENT'S EDUCATI (Specify only highest grade com	pleted)	18a. DECEDENT'S ((Give kind of w life. Do NOT use	ork done during m	ON ost of working	16b. KIND OF BU	JSINESS/INDUST					
COMPLETED	N/A	ollege (1-4 or 5 +)	CEMENT	FINIS			TRUCT	ION				
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide	n Surname)					
H	SHERMAN R. COAT 198. INFORMANT'S NAME (Type/Print)	ES	19h MAII ING	ADDRESS (Street	ARDELL	A BRIGH Route Number, City or To		del				
임	MRS. ARDELLA COA	TES			TERY AV	E. BALT	O.,MD.	21229				
	20s, METHOD OF DISPOSITION Burlel 2 Cremetion 3 Removal Donation 5 Other (Specify)	trom State cem	PLACE AND DATE O			0/18/95	RAT.TC	y or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LICENS	LEWIS		VITAL NAME A	ND ADDRESS OF FA	GWYNN FU						
	+ Levis	Gwynn	,			HEIGHTS		BALTO., MD.				
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallura. List only one cause on each fina. IMMEDIATE CAUSE (Final disease or condition as CANCER of THE PHARYNX a. CANCER of THE PHARYNX											
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL (PART II. Other significant conditions c			n the undarlyin	g cause givan in		N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
Ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE O		S NO [3 01100111111	N 🗆						
<u>S</u>		OSPITAL:	28. PLACE OF DEAT	OTHER:								
H H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TiME		JURY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED				
	1 Natural 5 Pending	(Month, Day, Year)	INJ		YES 2 NO	-						
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Spec		treet, tectory, offi	ca	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best at my know	lados dasth occurs	d at the time dat	and place, and due	to the cause(s) and m	anner se stated					
M	one)							suse(s) and menner as stated,				
	296. RIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IGNED (Month, Day, Year)				
O BE	Muhler	Non	ALL		D29	170	614	115/95				
5	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE			05 BH	717 ino/	LE M	0 2/201				
	31. OCT 1. 9 1995 Jal	35 EGIS RAR'S AN	A UNIC			•						

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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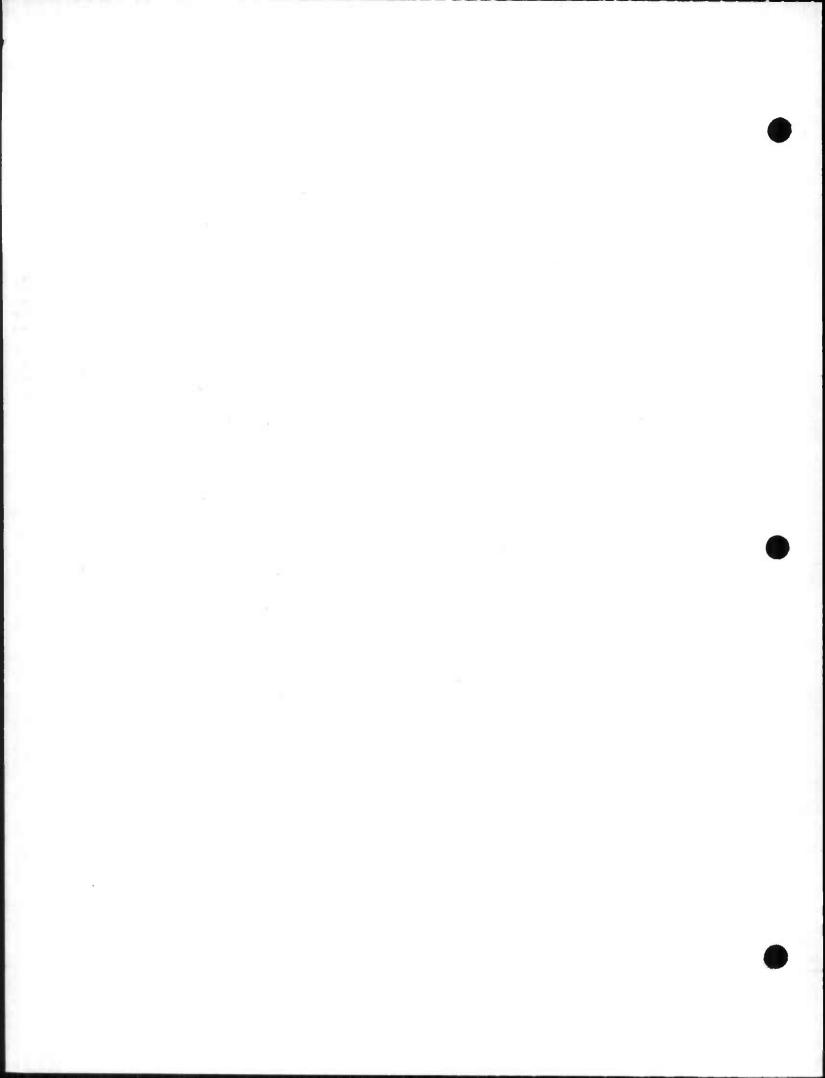
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

3	1. DECEDENT'S NAME (First) DANTE		ERICK DOU	JGLAS, SR						2. DATE OF D	DAY	5.199	YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 214 26 531		5. SEX 1 🔀 M 2 🗌 F	6. AGE (In yrs. less		F UNDER 1 YE		IF UNDER	24 HRS. MIN.	7. DATE OF B (Month, Des) 04 12	IRTH			ACE (State or Foreign and
OR	9a. FACILITY NAME (If not in Bay View I	Medica			9	96. CITY, TOWN OR LOCATION OF DEATH Baltinmore						ec. COUN	TY OF DEA	тн
2	RESIDENCE OF DEC	10b, COUNTY	,		100 CITY I	TOWN OR L	OCATIO	NA.					1,	Od. INSIDE CITY
DIRECTOR	Md.	IOD. COOM?	N/A			Balti								LIMITS? X YES 2 NO
FUNERAL	100. STREET AND NUMBER 6919 E. 1		ore Stre	et			14.0	2122				EN OF WH	AT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 🔀 3 Wildowed 4 Divo	Married	12. WAS DECEDER	NT EVER IN U.S. ARI I VES 2X N MAR OR DATES	NO If yea, specify Cuban, Ma					n, Puarto Rican			- American Indian, White, etc.	
0	15. DEC	EDENT'S EDU	CATION	18a. DE	CEDENT'S US	UAL OCCU	PATION			16b, KIN	D OF BUS	INESS/IND		
COMPLETED	(Specify online Elementary/Secondary (I	+)	ve kind of wor Do NOT use r et Met				ng	C	onst	ructi	.on			
17. FATHER'S NAME (First, Middle, Leet) Daniel Edward Douglas 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Barlow														
TO B	Jacqueline		uglas							Route Number, C Balto				Jac.
	20a. METHOD OF DISPOSIT 1 St Burlal 2 Crematic 4 Donation 5 Other	ION on 3 Ram r (Specify)	oval from State	cemetery, cre	nd DATE OF	r place)			10-	19-95		stwo		
	4 Donetton 5 Other (Specify) Oak Lawn Cemetery 10-19-95 Eastwood, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler & Son Inc.													
	► Che	ule	9.3	ala						Ave. B				
CERTIFICATION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
5			d		_									
MEDICAL	D. M	صماء	reaulting in the underlying cause given i					10	Part i. 24s. WAS AN AUTOPSY PERFORMED?			VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO		
Ž	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAII					
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL:	4	E OF DEATH	THER:							_	
ΥS	1 TYES 2 NO		-	ER/Outpatient 3	1		_		esidence	6 Other (Sp				
ВУ РН	27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation		Day, Year)	26b. TIME	M 1	WOR YE	IK?	□ NO	28d. OEŞCRII	BE HOW II	NJURY OCC	URED	
										ute Number,				
COMPLETED	and and		ICIAN: To the best of											and manner so atated.
TO BE	296. SIGNATURE AND TITU			M.D.				29c. LIC	L Z	752		29d. DATI	10/18	Month, Day, Year)
-	M. Wel		10 COMPLETED CA		M 27) (Typo, P	rint)	>	4		Bal-	+-	MZ	2	-1224
31. DATE FILEO (Month, Day, Yber) OCT 1 9 1995 July Dawder Revolution														





DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transft

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF		DEPARTMENT			MENTAL	HYGIENE
	C	ERTIFICATE	OF DEAT	THE S		050 110

	1. DECEDENT'S NAME (First, Middle, Las	4			ATE OF		2. DATE	OF DEATH		3. TIME OF DEATH
	- Edward D	evere EDWA	ARD D.	DeVere				tober		195 04:10
	4. SOCIAL SECURITY NUMBER 217–20–6483	5. SEX 6. AG	68 (In yrs. lest	"	OTHS DAYS	HOURS MM.	7. DATE	of BIRTH	0.	BIRTHPLACE (State or Forei
TOR	9a. FACILITY NAME (If not institution, gived Union Mem RESIDENCE OF DECEMENT	orial Hosp	ital	96.	Balt	imore (City		9c. COUNTY	Y OF DEATH
DIRECTOR	Maryland Bal	timore City			own or local					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3917 Falls Road				10	21 21 1				S.A.
ВУ	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced	12. WAS DECEDENT, EVER FORCES? 1/2/1/19 IF YES, GIVE WAR OF	DATES	MED O	If yes, sp	CENDENT OF HISPA Dealty Cuban, Maxic 3 2 NO Speci	an, Puerto F		s or No.— 14	I. RACE — American Indian, Black, White, atc. Specify: White
PLETED	15. DECEDENT'S EE (Specify only highest gra Elementary/Secondary (0-12)		(Gh	CEDENT'S USU We kind of work Do NOT use ret	done durina mi	ON ost of working		KIND OF BUS	siness/inous Produ	
E COMPL	17. FATHER'S NAME (First, Middle, Last) Sidney Salvado	or			-	18. MOTHER'S N. Lorre		Middle, Meiden DeVel		
TO B										
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stemation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of other Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Stematics) of Other (Specify) 20b. PLACE AND DATE OF DATE									
	22. NAME AND ADDRESS OF FACILITY Burgee—Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland (23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	snock, or neart tellure	e. List only one ceuse on			inter the mo	de of dving aug	ch as card	liac or reani	irstory arrest	t Approximate
	dissess or condition resulting in death)	e. Cardia	C An	VECT						t, Approximate Interval Betwoen and D
CERTIFICATION	disesse or condition	b. Adult Due to (or As Due to	C Ar S A CONSEO RLS P S A CONSEO	UENCE OF):						Onset and D
REDICAL CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	b. Adult (DUE TO (OR A) C. Phaumo DUE TO (OR A) C. Colon (S A CONSEQUENCE S A CONSEQUENC	VECT UENCE OF): UENCE OF): UENCE OF):	y di	2 2297 12	Synd		AUTOPSY IMEO?	Interval Betwonset and D 10 mi 3 down 5 down 2 month 24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
AN: MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. Cardia DUE TO (OR A) b. Adult (DUE TO (OR A) c. Phauma DUE TO (OR A) d. Colon (ona contributing to death	S A CONSEO S A CONSEO S A CONSEO D but not re	UENCE OF): UENCE OF): UENCE OF): UENCE OF): UENCE OF):	y du	ST YESS _C	Synd Part I.	24a. WAS AN PERFOR	AUTOPSY IMEO?	Interval Bety Onset and D 10 mi 3 down 5 down 2 month 24b. WERE AUTOPSY FINDI AMILABLE PRIOR TO COMPLETION DE CAU
SICIAN: MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions.	a. Cardia DUE TO (OR A) b. Adult (DUE TO (OR A) c. Phauma DUE TO (OR A) d. Colon (ona contributing to death	S A CONSEO S A CONSEO D but not re OF DEAT 26. PLACE	UENCE OF): UENCE OF): UENCE OF): UENCE OF): CH YES [E OF DEATH (C) OT	e underlyin NO [heck only one)	g cause given in	Synd Part I. N 🗹	24a. WAS AN PERFOR	AUTOPSY IMEO?	Interval Betwonset and D 10 mi 3 down 5 down 2 month 24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
PHYSICIAN: MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions of the cause of the	a. Cardian DUE TO (OR AS b. Adult DUE TO (OR AS c. Pre Umo DUE TO (OR AS d. Colon (TRIBUTE TO CAUSE HOSPITAL: 1 Inpettent 2 ER/O. 28a. DATE OF INJUR (Month, Day, Year)	S A CONSEO S A CONSEO S A CONSEO Duty not re OF DEAT 26. PLACE utpettert 3	UENCE OF): UENCE OF): UENCE OF): UENCE OF): CH YES [E OF DEATH (C) OT	e underlyin NO [heck only one) HER: Nursing Hom 28c. INJ	ST YESS _C	Synd Part I. N 19 6 - Other	24a. WAS AN PERFOR	AUTOPSY IMEO?	Interval Betwonset and D 10 mi 3 closs 2 month 24b. WERE AUTOPSY FIND ANALABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 VES 2 (FINO
TED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Dieses or Injury that initiated events resulting in death) LAST PART II. Other significent conditions. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	a. Cardian DUE TO (OR AS b. Adult DUE TO (OR AS C. Pre Unit DUE TO (OR AS C. Colon (Colon (TRIBUTE TO CAUSE HOSPITAL: 1 Tinpatient 2 ER/O 28a. DATE OF INJUR (Morth, Day, Year	S A CONSEO S A CONSEO S A CONSEO S A CONSEO Dut not re OF DEAT 26. PLACE utpetlent 3 Y RY — At hon	UENCE OF): UENCE OF): UENCE OF): UENCE OF): UENCE OF): OF DEATH (OT DOA OT HNJURY	NO Check only one) HER: Nursing Hom 28c. INJ. WC	g cauae given in UNCERTAI 10 5 Raeldence 1URY AT 19167 1925 2 NO	Synd Part I. 6 Other 28d. DES	24a. WAS AN PERFOR 1 YES 2	AUTOPSY IMEO? IL NO	Interval Betwonset and D 10 mi 3 closs 2 month 24b. WERE AUTOPSY FIND ANALABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 VES 2 (FINO
LETED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CON 25. Was CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of the Could not be determined. 29a. CERTIFIER (Check only)	a. Cardial DUE TO (OR AS b. Adult DUE TO (OR AS C. The Unit DUE TO (OR AS C. Colon (d. Colon (TRIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/O 26a. DATE OF INJUR (Month, Dey, Year 28a. PLACE OF INJUR 28a. PLACE OF INJUR 28a. PLACE OF INJUR 28a. PLACE OF INJUR	S A CONSEO S A CONSEO S A CONSEO S A CONSEO D but not re OF DEAT 26. PLACE utpettent 3 Y Y RY — At hom poorly)	UENCE OF): UENCE OF): UENCE OF): UENCE OF): UENCE OF): OF DEATH (COME OF INJURY) The farm, street of the occurred at	In the time, date	g cause given in UNCERTAI THE 5 Residence THE 7 PK 2 NO	Part I. 6 Other 28d. DES	24a. WAS AN PERFOR 1 YES 2 Tr (Specify) CRIBE HOW III ATION (Street a pr Town, State)	AUTOPSY IMEO? IV NO NJURY OCCUR and Number or I	Interval Betwonset and D 10 mi 3 closs 2 mcn th 24b. WERE AUTOPSY FIND AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 MNO RED Rural Route Number,
ETED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CON 25. Was CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of the Could not be determined. 29a. CERTIFIER (Check only)	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS COLON (COLON (DE TO (OR AS DUE TO (OR AS DUE TO (OR AS COLON (DOI: 10 (OR AS DUE TO (O	S A CONSECTION OF DEAT 26. PLACE Utpettert 3	UENCE OF): UENCE OF): UENCE OF): UENCE OF): UENCE OF): OF DEATH (COUNTY OF THE OF INJURY) The, farm, street the occurred at the occurred	NO heck only one) HER: Nursing Hom 1 1 Nation, office The time, deta my opinion, d	g cause given in UNCERTAI THE 5 Residence THE 7 PK 2 NO	Synd Part I. 6 Other 28d. DES 28r. LOCA City c	24a. WAS AN PERFOR 1 YES 2 (Specify) CRIBE HOW II ATION (Street a per Yown, State)	AUTOPSY IMEO? IN NO NJURY OCCUR and Number or I	Interval Betwonset and D 10 mi 3 closs 2 mcn th 24b. WERE AUTOPSY FIND AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 MNO RED Rural Route Number,

. As a second of the second of

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFIC			MENTAL HYGIEN REG. NO			
ij.	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	11101111111	LLEN	ELK	CINS	SR.	OCT. 16, 1	1995	16:30 P M	
			MO.	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	FEB To BIRTH	8.	BIRTHPLACE (State or Foreign Country)	
	220 02 2011	1 × M 2 F 3	2 YRS.						
OR	99. FACILITY NAME (If not institution, give stree UNION MEMORIAL			BALTI	MORE	ATH	9c. COUNTY BALT	IMORE CITY	
DIRECTOR	toe. STATE BALTI.	MORE CITY	10c. CITY I	TIMORE	CITY			10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER			10	1. ZIP CODE 21218		10g. CITIZEN	YES 2 NO	
FUNERAL	1522 Oakridge Rd				21218		USA		
В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	Never Married 2 Merried FORCES? TO YES 2 NO				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 YES 2 NO Specify:			
PLETED	ts. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-t2) 5 th		16a. DECEDENT'S USI (Give kind of work life. Do NOT use re Handymar	done during me tired.)	ON ost of working		employed		
COMPLET	17. FATHER'S NAME (First, Middle, Last) CHARLES	ELKIN	IS		18. MOTHER'S NAME WANDA	AE (First, Middle, Malden WILI	Sumeme) IAMS		
TO BE	190. INFORMANT'S NAME (Type/Print) MICHAEL A W ELKIN	S, JR.	19b, MAILING AD 198 B1a	oness (Street	and Number or Rural R	oute Number City or Tow 129 Fayett	m. Stete, Zip Co Ceville	PA 17222	
	20e, METHOD OF DISPOSITION 1		PLACE AND DATE OF D lery, crematory or other LITO Crema		arne of	1		or Town, State 1e, MD	
	21. SIGNATURE OF FUNE ALL SERVICE LICENTAL Dean P Charlton			²² NAME A	TON FUNE Eastern	THE STATE OF THE S	imore,M	D 21231	
	23. PART I. Enter the diseases, or co- shock, or heart feilure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ATHEROSCLER(on line.			as cardiac or reap	Iratory arrest	Approximata interval Batween Onset and Death	
NOI	DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF):								
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury								
CERTIFICATION	that initiated events requiting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
	DADT II Other elgoidleant conditions	contributing to death by	A mak unnulklam la d	har a mala alada	a server along to t				
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AMAIL COMP OF DE								
ä	DID TOBACCO USE CONTRI					1 🖾			
PHYSICIAN:		HOSPITAL:		Check only one					
IYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpa	tient 3 DOA 4		JURY AT				
BY PH	1 XXNatural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		ORK?	28d. DESCRIBE HOW	INJURY OCCUR	RED	
60	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special	— At home, farm, atre	et, fectory, offi	ce	28f. LOCATION (Street City or Town, State		Rural Route Number,	
COMPLET	onel only	AN: To the best of my knowle On the beele of exemination						euse(s) end menner ee stated.	
8	29b. SIGNATUNE AND TITLE OF CERTIFIER	2. Ch	ut me		29c, LICENSE NUM		l.	IGNED (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri	int)					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 6876

DENNIS 31. DATE FILED (Month, Day, Year) OCT 1 91995

CHUTE

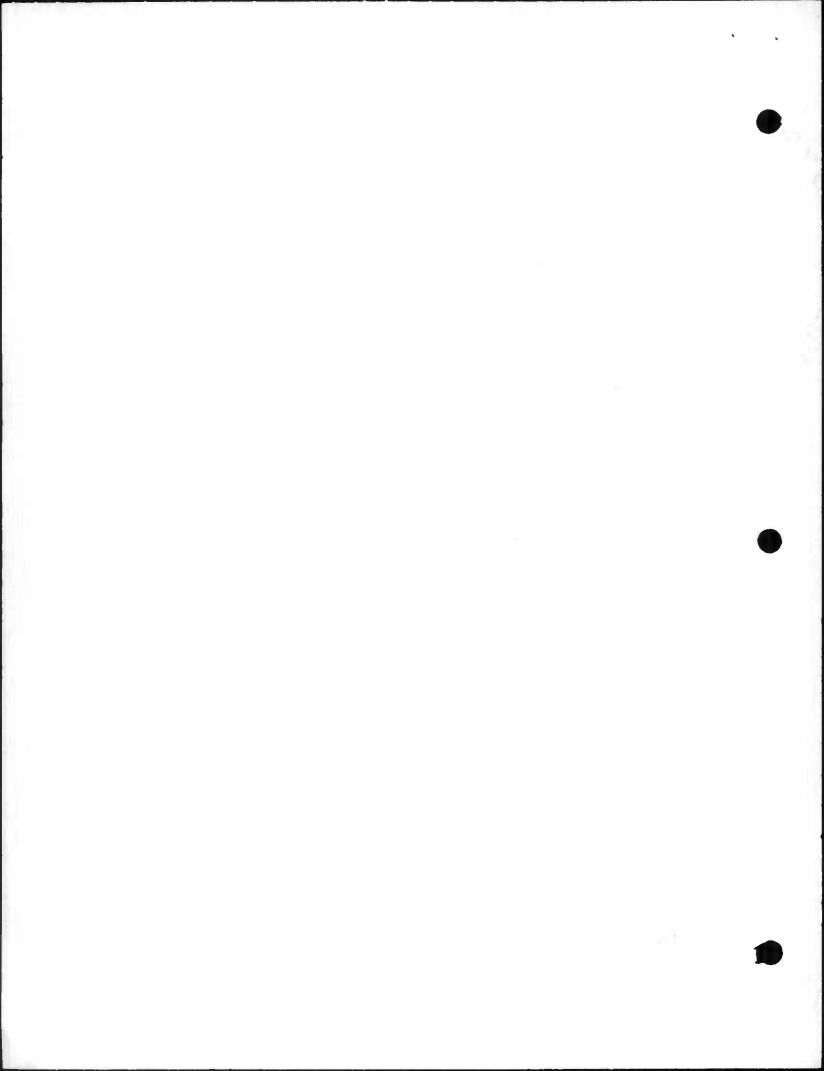
111 Penn Street, Baltimore, Maryland 21201 22. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. Pages 1, 2, 3 should DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. requires that the death certificate be executed within TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law ITO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 s

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH 70: 9:13A 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 7. DATE OF BIFTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS TOWN OR LOCATION OF DEATH 9b. CITY, 9c. COUNTY OF DEATH 08 arc:ssus DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Hmore YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Narcissus ·A Avenue 21215 5 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 14. RACE - American Indian, Black, White, etc. FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 2 Married If yes, specify Cuban, Maxican, Puerto Ri 1 YES 2 NO Specify: 1 Never Married BY Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) NA 1100 enmar er co once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maider Sumame Haga to BE notified 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number 2 Ethe 212-18 must be METHOD OF DISPOSITION
Burlel 2 Cremation 3 205 PLACE AND DATE OF DISPOSITION (Na LOCATION - City or Donation 5 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 21215 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, Approximata ahock, or heert fellure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** 1 disease or condition METASTATIC PROSTATIC CARCINOMA YR traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): INSUFFICIENCY RENAL YR CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING HEPATIC MOS INSUFFICIENCY CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any ADULT ONSET DIABETES 1 □ YES 2 NO OF DEATH? 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL OTHER: 1 - YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 M Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO ΒY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) ETED 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide detarmined COMPL 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MA PhD 046104 10 35) mag 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT 0 RUOWSILI 600 N. WOLFE ST MS BALTO 2128-

5+1

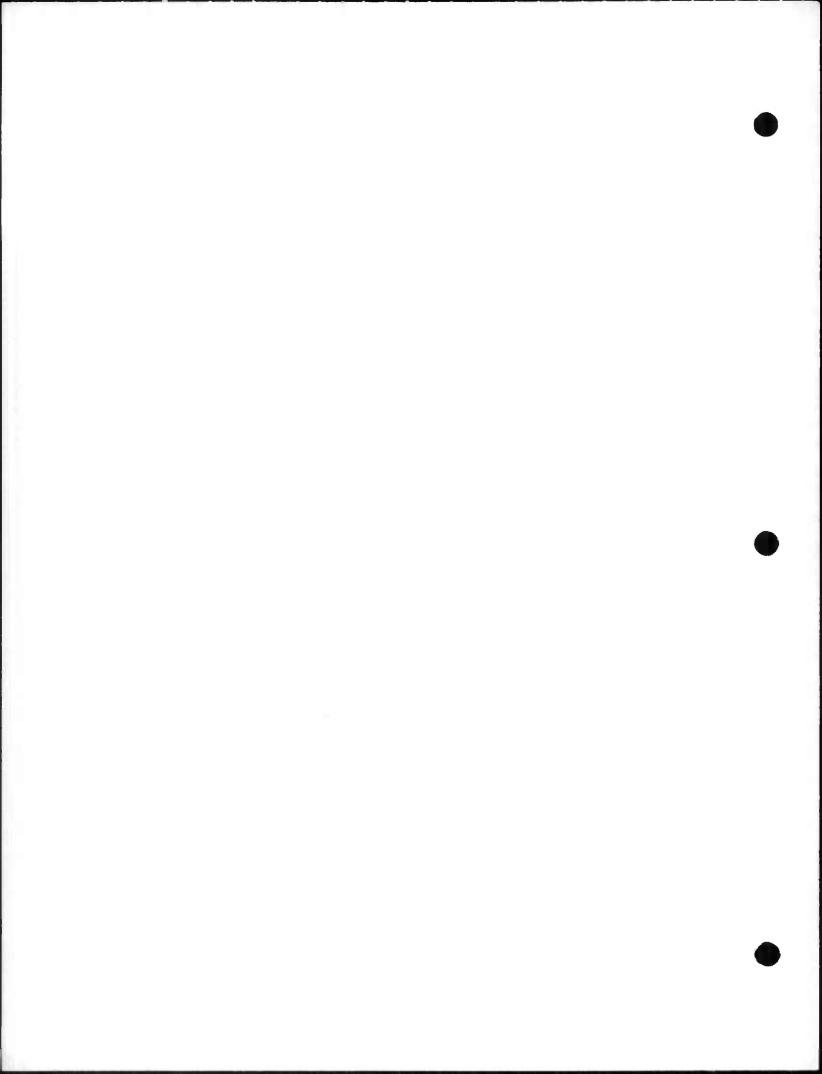




FOR STATE

	REGISTRAR		CERTIF	ICATE (OF DEATH	RE	G. NO.			
	1. DECEDENT'S NAME (First, Middle, Lust) Joan Marie Faull					2. DATE OF DE MONTH OCt.	17, 19	95	3. TIME OF DEATH 8:45 P M	
		M 2 🔀 F 57	s. lest birthday) YRS.	MONTHS DA	ONTHS DAYS HOURS MIN. July, 3,1938 Ma				HPLACE (State or Foreign try) ryland	
DIRECTOR	99. FACILITY NAME (if not institution, give street end 2205 Southorn Road RESIDENCE OF DECEDENT			Middle River			9c. COUNTY OF DEATH Baltimore			
EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION				10d, INSIDE CITY	
	Maryland Baltimo	ore		Mid	lle Rive	r	1 10 01		10d. INSIDE CITY LIMITS? 1 YES XX NO	
FUNERAL	2205 Southorn Roa			21220			Ţ	what country?		
ВУ	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	S. ARMED	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 15 yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:			14. RAC Blec Spec	E — American Indian, k, Whita, etc. #y: White			
0	15. DECEDENT'S EDUCATION (Specify only highest grade complete	nd) 164	DECEDENT'S	USUAL OCCUP	ATION	16b. KIND	OF BUSINESS/INC	DUSTRY		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) File Clerk 16. KIND OF BUSINESS/INDUSTRY Social Security 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. MOTHER'S NAME (First, Middle, Meiden Surname)								tv		
0	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA					
BE C	Clarence Luxenbero	ger				ret Ta	·R			
6	19e. INFORMANT'S NAME (Type/Print)				eet and Number or Rural					
	Howard R. Faulkner				orn Rd.					
	20a. METHOD OF DISPOSITION 1 General 2 Command 3 Removal fro 4 Donation 5 Other (Specify)	m State 20b. PL/	ACE AND DATE O	of DISPOSITION	Mame of	DATE	20c. LOCATION —	City or To	own, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	, die		22. NAM	E AND ADDRESS OF FA	CILITY	333 Ba	LCIII	iore, MD.	
- 0	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND APPRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt., MD. 21221									
z	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CNS Luciente Due to (or as a consequence of):								Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CO		7:	ukemo	J				
	PART II. Other significent conditions contri	ibuting to deeth but r	ot resulting i	n tha underl	ving ceuse givan in	Part 1. 24a. 1	WAS AN AUTOPSY	246	. WERE AUTOPSY FINDINGS	
MEDICAL						10	PERFORMED? YES 2 1 NO		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100	
Z	DID TOBACCO USE CONTRIBUT					NO			176	
<u>S</u>		PITAL:	PLACE OF DEAT	OTHER:	ne)					
PHYSICIAN:		petient 2 ER/Outpetier			iome 5 K Rasidenca					
ВУ РН	1 Naturel 5 Pending 2 Accident Investigation	Be. DATE OF INJURY (Month, Day, Year)	26b. TIMI	URY	INJURY AT WORK? YES 2 NO	26d. DESCRIBE	HOW INJURY OC	CURED		
	3 Suicide 8 Could not be 4 Homicide determined	Ba. PLACE OF INJURY — J building, etc. (Specify)	it home, farm, a	treet, factory, o	ffice	26f. LOCATION City or Town	(Street and Number n, State)	or Rural I	Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the								i) and menner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CHITTEEN	1			29c. LICENSE NU	WBER	29d. DAT	E SIGNED	(Month, Day, Year)	
TO B	30. NAME AND ADDRESS OF PERSON WHO COMP	ka MD	#7F44 07 :-	21.4	D042	100	> 1	0/1	8/95	
	Philip J. BURKE		1064 C		hus Hopler	s Hesp	, Baltin	cu	EIN.	
	00-10	REGISTRAR'S SIGNATUR								





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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exflours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	nedistrian		CERTIF	ICALE	= UF	DEATH	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) FLOREN				FR	OST	2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest birthdey)	IF UNDER	1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, De	BIRTH ny, Your)		Countr	IPLACE (State or Foreign y)
	9e. FACILITY NAME (If not institution, give		7 .	9h CITY	TOWN	R LOCATION OF DE		- 21,	1921		
DINECTOR	Northwest Hospi			96. CITY, TOWN OR LOCATION OF DEATH Randallstown 8c. COUNTY OF DEATH Baltimore							
	10a. STATE 10b. COUN	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY		
	Md. Ba.	Ltimore	R	eiste							1 YES 2 NO
	234 Chartle	y Drive			101.	21136				S.S.	PHAT COUNTRY?
DI LONGUAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				f yes, spe	ENDENT OF HISPAN celfy Cuben, Mexica 2 X NO Specify	n, Puerto Rica	pecify Yes n, etc.)	or No-	14. RACE Black Speci	American Indian, white, stc.
3	15. DECEDENT'S ED (Specify only highest grad		16e. DECEDENT'S	USUAL OC	CCUPATIO	N	16b. KIN	ID OF BUS	INESS/INDU	STRY	
i I	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done d se retired.)	during mos	at of working					
	12 1 Hou				ewife Homemaker						
	17. FATHER'S NAME (First, Middle, Last) Leonard T. 1				18. MOTHER'S NA						
\$ -	19a. INFORMANT'S NAME (Type/Print)	Jean	100 1101				e Nora				
2						Drive, R	eister	stow	n, Shine, Zip o	. 2	1136
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rea 4 Donetion 5 Other (Specify)	of DISPOSI			DATE		ATION — C		,		
4 Donetion 5 Other (Specify) Metro Crematory Oct. 18, 1995 Baltimore, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel							, PR	21117			
	23. PART I. Enter the speeces, or shock, or neert fellure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. SEPS	on eech line.	A R	the mod		n ee cardlec	or reepin	atory erre	et,	Approximate Interval Between Onset and Death
	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C	AS A CONSEQUENCE OF								
	PART II. Other eignificent condition			n the und	derlying	cause given in		PERFOR	WED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEATH YE	S N	10 🗆	UNCERTAIN	<u> </u>				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	'H (Check o	only one)						
	1 TYES 2 NO	HOSPITAL:	/Outpatient 3 DOA	OTHER 4 - Number		5 - Residence	6 Other (Sp	ecify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJ (Month, Day, Y		E OF URY	28c, INJU WOF 1 Y	RK?	28d. DEŞCRI	BE HOW IN	JURY OCCU	IRED	
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN building, atc.	JURY — At home, ferm, a (Specify)	treet, fecto		2 7 10	281. LOCATIO City or To	N (Street as wn, Stete)	nd Number o	r Rural R	oute Number,
		SICIAN: To the best of my ER: On the basic of exami									and menner ea stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE		2			29c. LICENSE NUM D 3 7		7			(Month, Day, Year) Les 17,95
	30. NAME AND ADDRESS OF PERSON W	HO, N			TIM	ure	MO	21	133	3	
	OCT 1 9 1995	32 REGISTRAR'S									



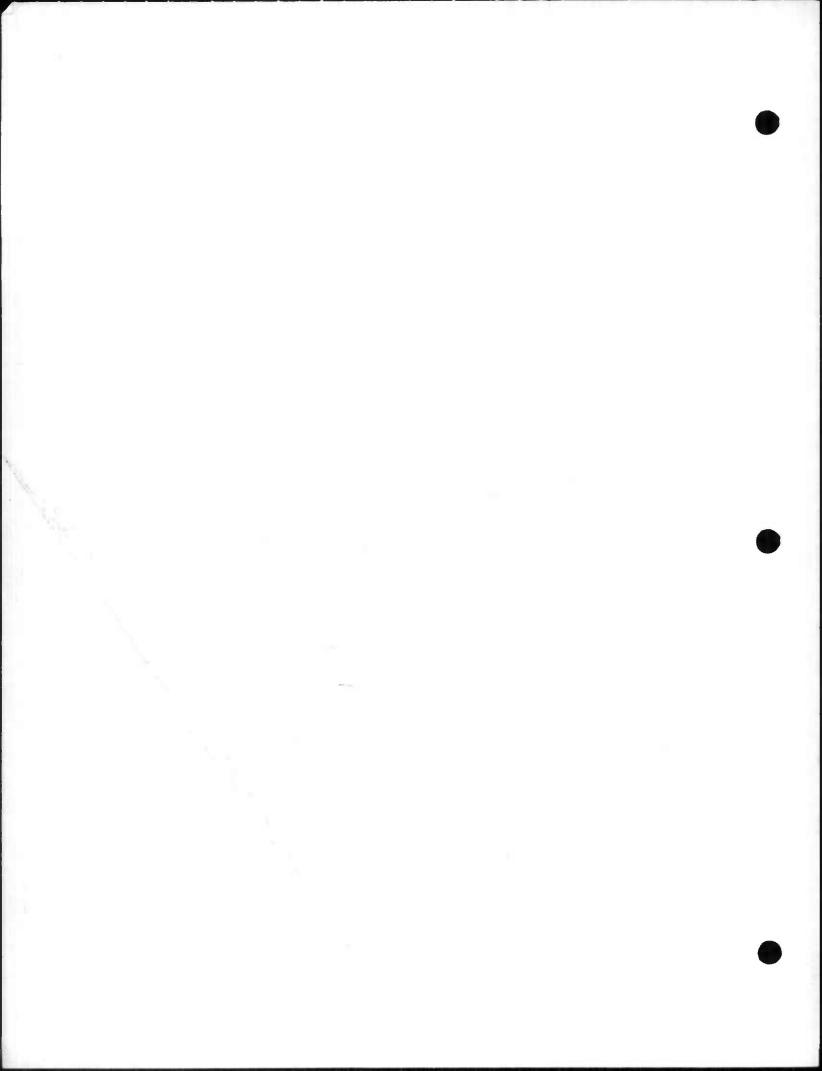
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the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Lest)	David L.				2. DATE OF DEATH	DAY 1995 YEAR	3. TIME OF DEATH 11:30 AM M	
	4. SOCIAL SECURITY NUMBER 214-64-8419	5. SEX 6. A	GE (In yrs. lest birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 16,	8. BIRT	INPLACE (State or Foreign	
TOR	96. FACILITY NAME (If not institution, give a 3644 Elm Avenue RESIDENCE OF DECEDENT	,			imore	EATN	9c. COUNTY OF	of DEATH ity	
DIRECTOR		ity	10c. CIT	y, town or locat Bal	timore			10d. INSIDE CITY LIMITS? XIXX YES 2 \(\square\) NO	
FUNERAL		Elm Avenue		101	ZIP CODE	1211	U.S.A.	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVE FORCES? 1 XX IF YES, GIVE WAR O	R IN U.S. ARMED ES 2 NO R DATES	If yes, sp	ENDENT OF NISPAL polity Cuben, Mexico 2XXNO Specif	NIC ORIGIN? (Specify Yen, Puerto Rican, etc.) by:	Blo	CE — American Indian, ck, White, atc.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Carpenter 17. FATNER'S NAME (First, Middle, Lest) Farl Francis Fisher Sr							USINESS/INDUSTRY	On	
9th Carpenter Construction 17. FATNER'S NAME (First, Middle, Lest) Earl Francis Fisher, Sr. Elizabeth Louise Lambert									
TO B									
	20e. METHOD OF DISPOSITION 1 Mauriei 2 Cremetion 3 Rem 4 Donation 6 Other (Specify)	oval from State	206. PLACE AND DATE of cametery, crematory or of Lake View	ther olecel		DATE 20c. L	ocation — city or t		
	21, SIONATURE OF FUNERAL SERVICE LIC	Carpen	the	Burge 3631	D ADDRESS OF FA CE-Henss Falls R	Funeral I	Home		
	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cau List only one cause or	sed the death. Do not asch line.	not snier ths mo	de of dying, suc	h ss cerdiac or res	piratory srrest,	Approximate interval Batween Onset and Death	
_		DUE TO (OR A	S A CONSEQUENCE OF					15 yrs	
CERTIFICATION	Sequantielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEQUENCE OF	·				g .	
	resulting in death) LAST	d							
EDICAL	PART II. Other algolificant condition	a contributing to deati	h but not resulting	In the underlying	cause given in	Part I. 24a. WAS A PERFO	RMED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE			UNCERTAI	N 🗆		1 TES 2 NO	
/SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PES 2 NO	HOSPITAL: 1 Inpetient 2 ER/O	26. PLACE OF DEAT	OTHER:	5 Reeldence	6 Other (Specify)			
	27. MANNER OF DEATN 1 Netural 5 Pending	26e. DATE OF INJUF (Month, Day, Yea			JRY AT	28d. DESCRIBE HOW	INJURY OCCURED		
TED BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJU- building, stc. (S	JRY — At home, farm, a (pecify)			28t. LOCATION (Street City or Town, Steff	t end Number or Rural a)	Route Number,	
COMPLET		CIAN: To the best of my kn						(e) and manner ee stated.	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	Italper	M		Da5	662	D 10/	D (Month, Pay, Year)	
	GREGORY (O COMPLETED CAUSE OF	DEATN (ITEM 27) (Type,	33 H, C	alred!	SX Suit 54	's BALT	VMD21218	
	" OCT 1 9 1995 A	32 REGISTRAR'S	NATURE						



1 - STATE REGISTRAR

DIRECTOR

FUNERAL

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BE notified

2

CERTIFICATION

MEDICAL

PHYSICIAN:

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BE

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EXAMINER?

1 Diffetural

2 Accident

3 Suicide

4 Homicide

27. MANNER OF DEATH

1 TES 2 NO

5 Pending

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

MATTHEWS

21061

Approximate

1 day

years

Interval Batween Onset and Death

1 YES 2 X NO

WHITE

1995 10:15 a.

MARYLAND

U.S.A.

Specify:

N/A

8. BIRTHPLACE (State or Foreign

REG. NO.

))	vermit. Pages 1, 2, 3	
BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	led in by the funeral director, page 5 should be detached for use as the burial-transit p , or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within er hours after death. Page 6 may be retained by the hospital or attending physician.	F. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	RTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH George A. **Custin** GEORGE ANSLEY GUSTIN October 18 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 218-22-6209 (Month, Day, Year) 08-23-1927 68 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION GLEN BURNIE ANNE ARUNDEL MARYLAND 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 374 MAJESTY GLEN GLEN BURNIE 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 3 Widowed 4 Divorced II WW 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sne STEAMFITTERS UNION LOCAL Elementary/Secondary (0-12) College (1-4 or 5+) STEAMFITTER 438 8 N/A 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGE GUSTIN AUDREY LAVINIA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Coo 374 MAJESTY GLEN, GLEN BURNIE, MARYLAND GEORGE A. GUSTIN, III 20g, METHOD OF DISPOSITION
1 W Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 1852 20c. LOCATION - City or Town, Stata GLEN BURNIE, MD. GLEN HAVEN MEMORIAL PARK 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE GLEN BURNIE. MARYLAND 21061 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Aortic valve disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

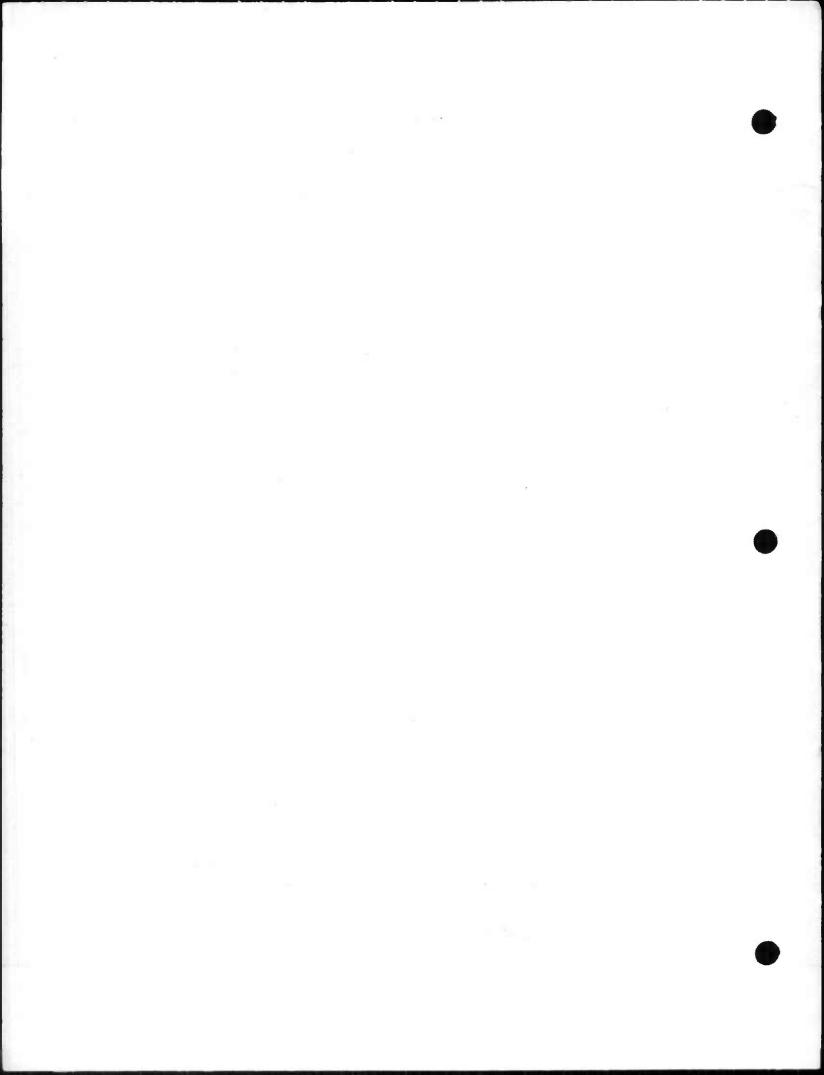
24s. WAS AN AUTOPSY PERFORMED? 24b. WERF AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 XYES 2 NO OF DEATH TYES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DDA OTHER: rsing Home 5 - Rasidenca 28a. DATE OF INJURY 28c, INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED M 1 YES 2 NO Investigetion 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 29s. CERTIFIER

**Chance could be considered at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the headed examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D30802 October 18, 1995 30. NAME AND ADDRESS OF PERSON WHO CONFLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21229 M.D. - St. Agnes Hospital - 900 Caton Avenue - Baltimore, Md. Jean M. Colandrea 37. BEGINERAR & SIGNATURE 31. DATE FILED (MORITI, Day, Year) OCT 1 91995 DHMH-18 Rev 1/89

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REGISTRAR				ERTIFIC	ATE OF	DEATH		REG. N	0.			
1. DECEDENT'S NAME (First, MANDIS	t.	m,	How	ARL			MONT	OF DEATH	DAY	YEAR 1995	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER 118-14-460	3 1	□ M 2 🏋 F	AGE (In yrs.	8 YRS.	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	July	OF BIRTH h, Day. Year) 21,	1907	Country	PLACE (State or Foreign	
9a. FACILITY NAME (If not instit	rive-V		. Mich		b. CITY, TOWN	Baltimor			9c. CO	UNTY OF DE	/a	
4500 Seton I RESIDENCE OF DECE	0b. COUNTY	n/a		0.00	TOWN OR LOCA						10d. INSIDE CITY LIMITS?	
100. STREET AND NUMBER		11/ a		De	altimor	I. ZIP CODE	_		10a. C	TIZEN OF W	1 X YES 2 ☐ NO HAT COUNTRY?	
10e. STREET AND NUMBER 4005 Oakford 11. MARITAL STATUS 1 Never Married 2 M						21215				USA	TAI COOKTATT	
3 Widowed 4 Divorce	rried	WAS DECEDENT: FORCES? 1 [IF YES, GIVE WAI	YES 2 1	NAMED NO	If yes, sp	WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes of It yes, specify Cuban, Maxican, Puerto Rican, etc.) \(\subseteq \text{YES 2 \overline{\text{Z}} NO Specify:} \)			es or No—	or No— 14. RACE — American Indian, Black, White, atc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY						33 20 00 12						
Elementary/Secondary (0-12) High School College (1-4 or 5+) Factory Worker Candy Company						y						
17. FATHER'S NAME (First, Midd						18. MOTHER'S NA						
Forest Conle						Victo						
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
Georgie L. Carter 4005 Oakford Avenue Baltimore, Maryland 200, Method of Disposition 200, PLACE AND DATE OF DISPOSITION DATE 200, LOCATION — City of Town, Stati							rn. Stete					
cometery, crametery or other place). Commetter Co							ounty, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, In 2501 Gwynns Falls Parkway Baltimore, Maryland 21216							Homes, Inc.					
23. PART i. Enter the dise	eses, or comp	pilications that o	aused the d	leath. Do not	enter the mo	de of dying, suc	h ee care	flac or real	piratory a	rreat,	Approximate	
IMMEDIATE CAUSE (Final	t tonoto. Elet	only one couse			1						Interval Between Onset and Death	
disease or condition resulting in death)	a		m	tastet,	ic W,	reast (art	cef			reavs	
.	_	DUE TO (O	R AS A CONS	EOUENCE OF):								
Sequentially list condition if any, leading to immedia	te	DUE TO (O	R AS A CONS	EOUENCE OF):			-					
cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events		DUE TO (O	R AS A CONS	EQUENCE OF:								
Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	d							·				
PART II. Other aignificent	conditions co	entributing to de	eath but not	resulting in	the underlyln	g cause given in	Part I.	24s. WAS A			WERE AUTOPSY FINDINGS	
PART II. Other alignificent							_	PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
							[- 1	1 TES 2 NO	
DID TOBACCO USE		UTE TO CAU				UNCERTAIL	v 🗆					
DID TOBACCO USE 25. WAS CASE REFERRED TO N EXAMINER? 1 YES 2 1 NO 27. MANNER OF DEATH	HC	OSPITAL:			THER:			2 04				
27. MANNER OF DEATH		26a. DATE OF IN	JURY	28b. TIME C	F 28c. INJ	• 5 Residence		(Specify)	INJURY O	CCURED		
1 25 Indicates 2 Las	nding estigation	(Month, Day,	Year)	INJUR	M 1	RK? /ES 2 NO						
	uld not be armined	26s. PLACE OF I building, etc	NJURY At I (Specify)	ome, ferm, stre	et, factory, offic		28f. LOC. City	ATION (Street or Town, State	and Number	er or Rural Ro	oute Number,	
						and place, and due					and manner as stated.	
			-			29c. LICENSE NUN					Month, Day, Year)	
30. NAME AND ADDREST OF M	2	~				D37	573		•	10/17	A 4	
Jef Zibell	WA	7770	Pack			e Bal	tim	0~2	MD	212	02	
OCT 1 9 199	3 July	3 Estate	Mary Willy	7						-		
*											DHMH-16 Rev 1/8	





DIVISION OF VITAL RECORDS, P.O. BOX 68760

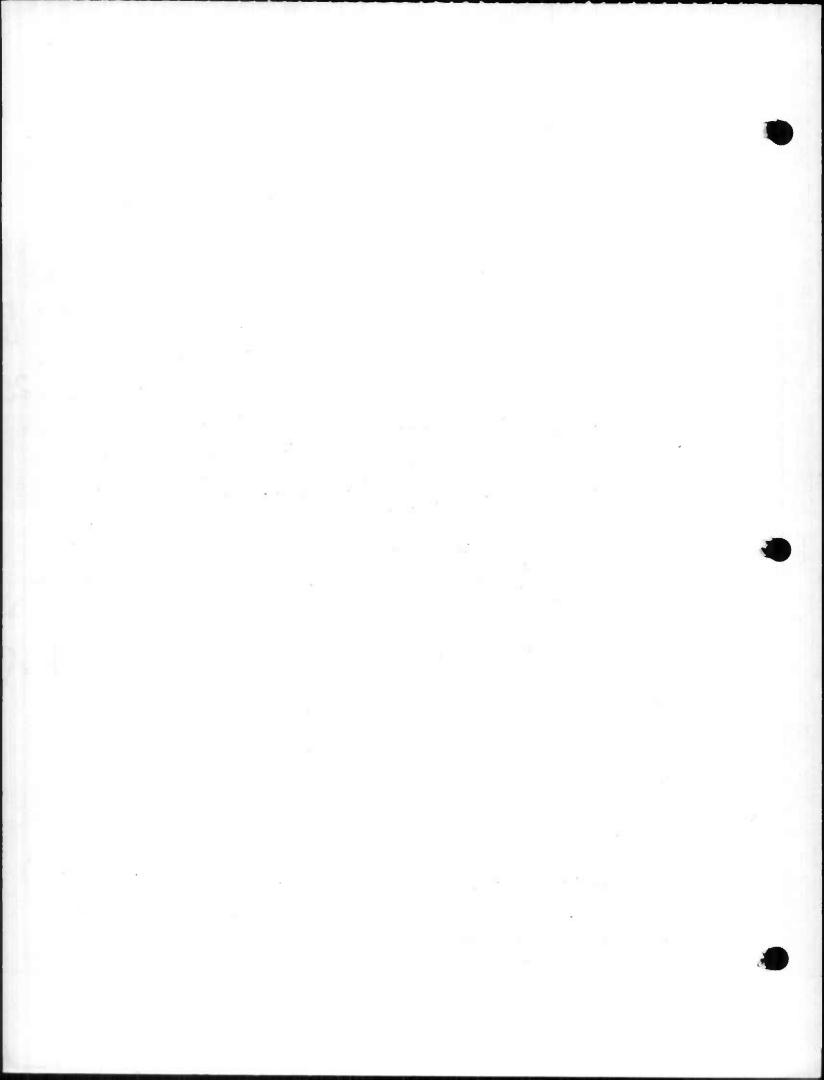
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1		FOR STATE
÷	_	REGISTRAF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_											
	1. DECEDENT'S NAME (First, Middle, Lest)	0	-					2. DATE OF DEATH	rA.	3. TIME OF DEATH	
- 1	OSCAR R Ingram							Oct. 12 1995 /165 PM			
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH 8.		8. BIRTHPLACE (State or Foreign "		
_	229-28-653	1 M 2 D F	70	YRS.	ONTHS DAYS	HOURS	BEN.	(Month, Day, Year)	24	North Corolinin	
- 1	De EACH ITY NAME IN not institution the of	201-01-627-			DE CITY TOWN	OR LOCATION OF DEATH		, , , ,	_	TY OF DEATH	
.	9a, FACILITY NAME (If not institution, give street and number)				PO. CITT, TOWN	0 1	·	AIR	Sc. CODA		
5	hiberty Medi	cu C	enter		Balto,				NA		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			to- OITY	TOWN OR LOCA	TION				10d. INSIDE CITY	
2	IOS. STATE			100. 0111,	1 11					LIMITS?	
5	MAKYLAND NA				Baltimore				1 BYES		
#	100. STREET AND NUMBER						21216			EEN OF WHAT COUNTRY?	
E I	2201 WALDFOOK Ave.						121	6		USA	
LONE	11, MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED 13, WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14, RACE —								14. RACE — American Indian, Black, White, etc.		
	1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puer IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:										
2	3 Widowed 4 Diversed									SpecifyBLacIC	
2								16b. KIND OF BU	SINESS/IND		
=	(Specify only highest grade	Ma	(Give kind of work done during most of working life. Do NOT use retired.)								
7	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4 or 5+)				= 10 (1)	neer	e Ballo	Pul	ELic Schools	
COMPLE	17, FATHER'S NAME (First, Middle, Lest)			wije	nary [18. MOT		ME (First, Middle, Melden	Sumana	orio ochionis	
3	10 1				1	1 V	TEN S NA		rle		
E E	Greely Ingt	am				1	1=3	310	-		
5	19e. INFORMANT'S NAME (Type/Print)	Time		, MAILING A	DDRESS (Street	and Numbe	r or Rund	Route Number, City or Tow	n, State, Zip	Code) 2/2/6	
	ELdamAe E.	Lingta	m	2201	WA	1510	bK	Avei	1301	Ho. Ind.	
	200. METHOD OF DISPOSITION	med from State	20b. PLACE A	ND DATE OF	DISPOSITION //	lame of	10/10	1/000 20c. LO	CATION - C	City or Town, State	
1 Buriel 2 Cremetton 3 Removal from State comotory, crematory or other place NATZ Mem, FR Lausal, Md,								, mal,			
	21. SIGNATURE OF PURERAL SERVICE LIC	ENSE		1	22. NAME	AND ADDRE	SS OF FA	CILITY	16:	39 Ni	
	V lexy	1601	Pour		Tex	sc n	1 11.00	, FILP.C.	B	roadway	
	TINA	y ru	cer		3-1	* "	111190	OTH			
	23. PART I. Enter the diseases, or cahock, or heart fallure.				t enter the m	ode of dy	ing, auc	h aa dardiac or reap	iratory arr	eat, Approximate Interval Batween	
	IMMEDIATE CAUSE (Final								Onset and Daeth		
	disease or condition	. 1	iver fo	rille	re						
	readiting in deetil)	DUE TO		DUENCE OF	:						
7	_		letasta	the	Colon	Car	NCE			1.5 UVS	
2	Sequentially list conditions,	DUE TO	OR AS A CONSEC	DUENCE OF	:					1	
CALION	If any, laading to immediata cause. Enter UNDERLYING									15-30-25	
	CAUSE (Disease or Injury that initiated eventa	CDUE TO	O (OR AS A CONSEC	DUENCE OF	:						
KIL	resulting in death) LAST										
SE	d										
1	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTO PERFORMED?								24b. WERE AUTOPSY FINDINGS		
3										AVAILABLE PRIOR TO COMPLETION OF CAUSE	
								1 TYES	- Nuo	OF DEATH?	
Σ	1 YES 2 NO										
HYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LA UNCERTAIN N										
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
S	1 TES 2 NO	1 Inpetient 2	☐ ER/Outpetient 3		4 - Nursing Ho	me 5 F	Residence	6 Other (Specify)			
T.	27. MANNER OF DEATH	28e. DATE O	F INJURY Day, Year)	28b. TIME		JURY AT		28d. DESCRIBE HOW	INJURY OCC	CURED	
	1 Neutral 5 Pending Investigation			M 1 TES 2 NO			□ NO				
3 Suicide 8 Could not be determined determined 286. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 286. PLACE OF INJURY — At home, ferm, atreet, factory, office City or Town, State)							or or Rural Route Number,				
							Only or lown, State	310)			
Щ	29e. CERTIFIER **Conclude: 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.										
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred.											
Ö	Z J MEDICAL EXAMINE	On the been of	examination end/or	investigation	, in my opinion,	deam occi	DIPOG BIL TIN	time, date end piece, e	no que to tri	a cesses(s) and manner as stated.	
29d. LICENSE NUMBER 29d. DATE SIGNED (N							E SIGNED (Month, Day, Year)				
							CT 13 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE ON DEATH (ITEM 27) (Type, Print)						1					
Charles A radgett NO, 5601 Lock Haven Klud, Beltimore MD							Move M)				
	31. DATE FILES (Mayth Profiter)	P Decision	AR'S MONTURE	,				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-(1		
	1 00 1 3 1333 A	THE WILLIAM	ST-GARAGEN								



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BALT	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Vernell A		Ji	-,	Oct.		95 5:59 A M			
		5. SEX 6. AGE (I	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign				
	215-88-8076	THE DAYS	B DAYS HOURS MIN. (Month, Day, Year 10-14-							
	Se. FACILITY NAME (If not institution, give stre	et and number)	96.	CITY, TOWN O	R LOCATION OF D	EATH	9c. COUNTY			
DIRECTOR	University Hospital Baltimore n/a									
2	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION 100. LOCATION									
E	MD	WIN ON EDGAI	Baltin	oro		10d. INSIDE CITY LIMITS?				
	MD n/a				ZIP CODE	1016	Tan CITIZEI	1 🖾 Xes 2 🗌 NO		
FUNERAL	900 Argyle Ave.				212	201	USA			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED			13. WAS DEC	ENDENT OF HISPAN	HC ORIGIN? (Specify Y	n or No- 14	or No.— 14. RACE — American Indian,		
	1 Rever Merried 2 Merried FORCES? 1 YES 2 TNO IF YES, GIVE WAR OR DATES			If yes, apo	2 DINO Specifi	n, Puerto Rican, etc.)		Black, White, etc. Specify:		
ВУ	3 Wildowed 4 Divorced				- 2,1,14	,	Black			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	iTION ompleted)	16a. DECEDENT'S USU (Give kind of work	done durina mos	N at of working	16b. KIND OF BI	JSINESS/INDUS	TRY		
<u>"</u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use ret	ired.)		macs				
N N	12th Counterperson McDo							9.3		
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide	-			
BE	Vernell E. Jor	ies	1		Catherine Hall (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
2	Catherine Penr									
	200. METHOD OF DISPOSITION							201		
	1202 Surial 2 Cremation 3 Remov		PLACE AND DATE OF DI		ne of	10/21 H		or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICE				D ADDRESS OF FA					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lanes A. Morton & Sons 7:17 Lanes A. Morton 1701 Laurens st									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. Castrointestinal Bleed Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. SOOSIS DUE TO (OR AS A CONSEQUENCE OF): c. COZ SULLOOZTA DUE TO (OR AS) CONSEQUENCE OF): d. LIVER FZILLE									
MEDICAL	PART II. Other eignificent conditions contributing to desth but not resulting in the underlying ceuse given in Part I. HIV — Hunan Immunode fieway Vilus YES 2 \(\text{NO} \) NO						RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2.5. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sic	EXAMINER?	HOSPITAL:	ОТ	HER:						
¥	27. MANNER OF DEATH	26s. DATE OF INJURY	28b. TIME OF	Nursing Home 28c. INJL		6 Other (Specify)	IN HIEV OCCUP	50		
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WOF		28d. DESCRIBE HOW INJURY OCCURED				
BY	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street,					28f. LOCATION (Street	CATION (Street and Number or Rural Route Number,			
品	4 Homicide 8 Could not be determined	building, etc. (Specia	(y)	,	City or Town, State)					
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.									
S I	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUW							
0	Claha M goldla - Min				PZNY	733	29d. DATE SIGNED (Month, Day, Year)			
2	36. IN ME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print)	101	100	UC	0.16/1995		
ı	The Cold Mariane									
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		Jone	1010	20116 21	10911	5.,MD 21201		
	OCT 1 91995 July Studger Real St									

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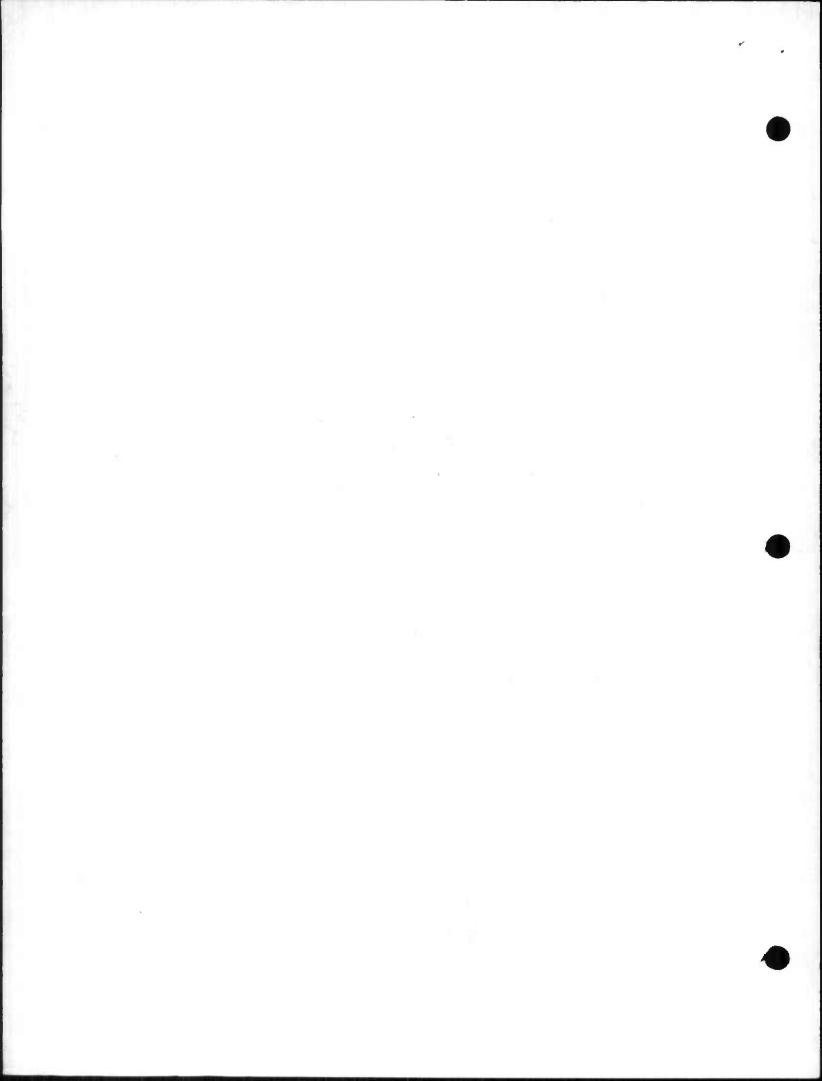
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	NTAL HYGIENI
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTM				HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH	DEATH DAY,	YEA	3. TIME DF DEATH
	ZELMA	JQ\				OCF	14	199	5 U. 36 MM
	4. SOCIAL SECURITY NUMBER 217-26-5314	1 DM 2 XF 70		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	ley, Year)		PUTTING OF Foreign
OR	PACILITY NAME (If not institution, give st	reneral Has	pital	. CITY, TOWN D	Sa +	EATH D		COUNTY C	OF DEATH
DIRECTOR	10e. STATE 10b. CDUNTY	JIA	10c. CITY, T	OWN OR LOCAT	ON				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	100. STREET AND NUMBER	+ Pack Au	le,	101.	ZIP CODE	07		log. CITIZEN,	OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U FDRCES? 1 YES IF YES, GIVE WAR OR DAT	2 ND	If yea, spe	ENDENT OF HISPAN	n, Puerto Rici			RACE — American Indian, Black, White, etc.
ED BY	3 Widowed 4 Overcad 15. DECEDENT'S EDUC	CATION	I6a. DECEDENT'S US		N		IND OF BUSIN		Specify: Back
COMPLETED	(Specify only highest grade	College (I-4 or 5+)	(Give kind of work life. Do NOT-use re	done during mos			7	Hom	e
	17. FATHER'S NAME (First, Middle, Last)	Hamlett			18. MOTHER'S NA	ME (First, Mide	dle, Maiden Su	mame)	
TO BE	194 INFORMANT'S NAME (Type/Palar)	mes	196.,MAILIND AD	OV	nd Number or Rural	Royte Number,	City of Town,	State, Po Cook	"/to, nd 21207
	20s METHOD OF DISPOSITION 1X Burlel 2 Cremetton 3 Ram 4 Donation 5 Quier (Specify)	oval from Stata	ACE AND DATE OF D	DISPOSITION (Na		1924	N	tion - city	Town, State Cand
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	,		D ADDRESS OF FA	CILITY	y 10	1110	11 010(11 Cg)
	* Maylen	4 few	10	MARCH	F/H-WEST				
		complications that caused t List only one cause on each	the death. Do not th line.	enter the mo	de of dying, auc	h aa cardia	c or respire	fory arrest,	Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE (Final disease or condition reauting in death)	· Jepsis							Ross
	_	necus Prus	CONSEDUENCE DE):						Month
NO I	Sequentielly list conditions, If any, leading to immediate	M	CONSEDUENCE DE:	1	1				7 000/29
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	· ConyeyTiv	y	u frost	lunt				Roys
CERTIFICATION	that initiated eventa resulting in death) LAST	d. Nensl	Fort (V)	ζ					Roys
AL C	PART II. Other algnificant condition	a contributing to death bu	t not resulting in t	the underlying	g ceuse given in	Part I. 2	4a. WAS AN AU		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PHYSICIAN: MEDIC	Mederthy	Harcia P	110VECK			1	YES 2	THO	COMPLETION OF CAUSE DF DEATH?
M	DID TOBACCO USE CONT				UNCERTAI				1 YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH		, or touch to				
rsic	EXAMINER? 1 YES 2 WHO	HOSPITAL: 1 Shipatient 2 ER/Outpet		THER: Nursing Hom	e 5 🗆 Rasidenca	8 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME D		RK?	28d. DESCF	RIBE HOW INJ	URY OCCURE	D
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY -	- At home, ferm, stre					d Number or R	ural Route Number,
TED	4 Homicide detarmined	building, atc. (Specif	y)			City or	Town, State)		
COMPLET	Control only	ICIAN: To the best of my knowle							use(s) and manner as stated.
BE C	296. SIGNATORE AND TITLE OF OURTIFIE	R			29c. LICENSE NU	MBER			GNED (Month, Day, Year)
TO B	To lily	m			1220	3/		1 0-	16-95
	Lange of Penson WH	O COMPLETED CAUSE OF DEAT	Le Mary	long.	on 3	30/2	2/2/	G	
11	31. DATE FILED (MÖNN, Day, Year) OCT 1 91995	32 REGISTRAR'S GNA	TURE	-					1 - 3



Pages 1, 2, 3 should

permit.

in and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. hours after death. requires that the death certificate be executed signed by the attending physician Health and Mental Hygiene prior to t. of H . OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept.

FUNERAL within 72 I HOSPITAL

91995

ITEM: 20b. PER F.H. FILM G-728 10/21/95 tt ITEM: 6. PER F.H. FILM G-728 10/19/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH 38 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR ?. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. Month, Day, Y -30-912 930 De. FACILITY NAME (If not institution, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Jinai RESIDENCE OF DE 10A STATE 10b. COUNTY 10c. CITY, TOV OR LOCATION 10d. INSIDE CITY THES 2 NO FUNERAL 104. STREET AND NUMBER 101. ZIP 10g. CITIZEN OF WHAT COUNTRY? Ave ramson 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—It yes, specify Suben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, atc. 1 Never Merried 2 Mar IF YES, GIVE WAR OR DATES Specify: 3 BY 3 Widowed 4 Divorced lack COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work dor life. Do NOT use retired ruck D. river once. 17. FATHER'S NAME (First, Middle, Last) notified at BE 196 YNFORMANT'S NAME (Type/Pris 2 Johnson ma 2878 (trud e Ba (10), 21215 2 Det METHOD OF DISPOSITION 10b. PLACE AND DATE OF DISPOSIT 20c. LOCATION City or To must onation 5 Other (Specify) the medical examiner OF FUNERAL BERVICE LICENSE NAME AND ADDRESS OF FACILITY wes1 H--23. PART is Enter the dispesses, or complications that ceused the death. Do not enter the shock, or heart feliure. List only one ceuse on each line. mods of dying, such as Approximata Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): event traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (DR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY shows any 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one, HOSPITAL: OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY 2 Accident 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, streat, tectory, office building, atc. (Specify) 28 is 3 Suicide COMPLETED Could not be 4 Homicide Hem 29e. CERTIFIER (Check only one) SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. = TO THE HOSPITA
TO THE FUNERAL
DE FILED WITHIN 72
IMPORTANT: 11 investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. THE SHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 2 31. DATE FILED (Month, Day

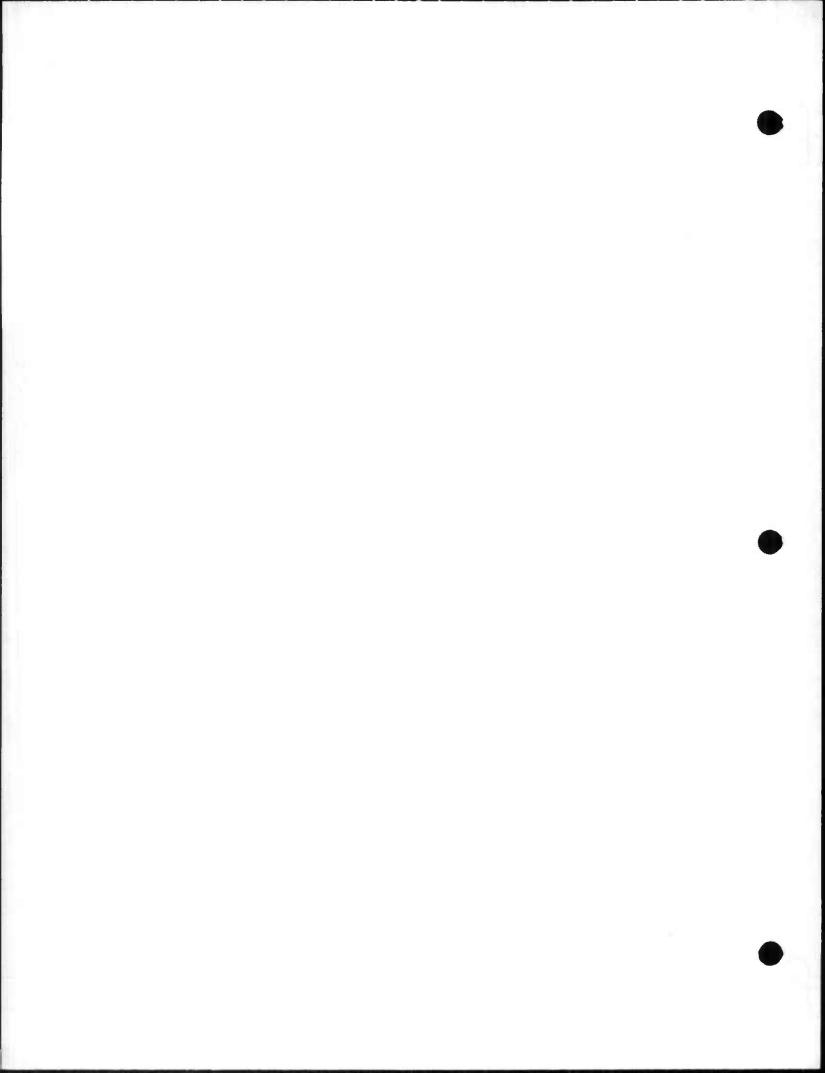
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

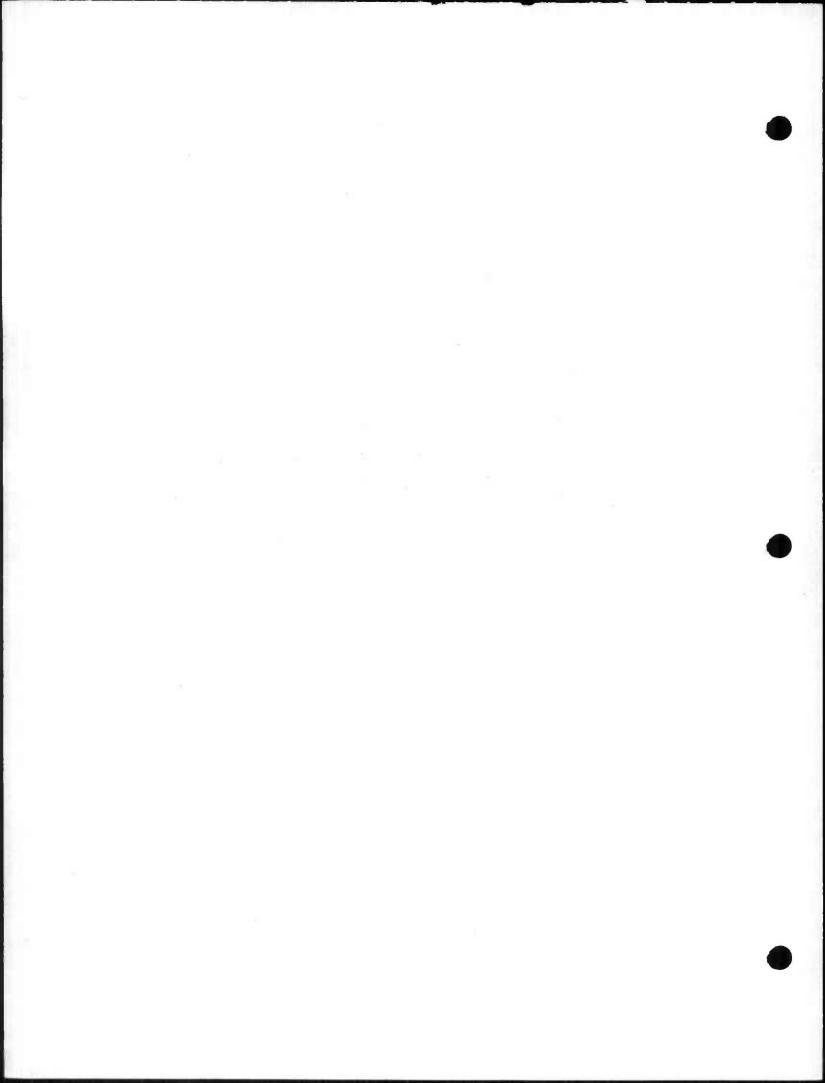
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAI	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3. TIN	E OF DEA	тн
	WILLIE MAE	E JAME	S			DCT.	16	1995		:25	Р. м
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8. 6	HRTNPLACE	(State or F	andra.
	210-40-3313	1 M 2 X F	80 YRS.	NTHS DAYS	HOURS MIN.	APR	IL 17,	1915 S	DUTH	CARO	LINA
~	9a. FACILITY NAME (If not institution, give stre	set and number)	96		R LOCATION OF D	EATN		9c. COUNTY			1.0
0	1927 W. VINE STRE	ET		BAL	TIMORE C	ITY		N/A	A		
EC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION				10d. J	NSIDE CIT	v
DIRECTOR	MARYLAND	N/A		BAL	TIMORE C	TTY			L	IMITS? YES 2	
	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZEN			, 1,0
ER	1927 W. VINE STRE	ET			212	223			USA.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED		ENDENT OF HISPA			or No.— 14.	RACE - Am	erican Ind	len,
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		city Cuban, Maxico 2 NO Speci		lican, etc.)		Black, White Specify:	, atc.	
	15. DECEDENT'S EDUCA	TION	[LACK		
1	(Specify only highest grade co	ompleted)	16a. DECEDENT'S USL (Give kind of work life. Do NOT use re	done during mos		16b.	KIND OF BUS	INESS/INDUST	RY		
2	Elemantary/Secondary (0-12) 7th GRADE	College (1-4 or 5+)	MAID				нО	TEL			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		HAID		18. MOTNER'S NA	ME (First A					-
	FRANK	FRIEDSON			MARION		nous, margon	SEYM	OUR		- 111
) BE	19a. INFORMANT'S NAME (Type/Print)	111111111111	19b. MAILING AD	DRESS (Street a	nd Number or Rural	Route Numb	er, City or Town	, State, Zip Code	0)		
၉	GLADYS WALKE	IR	31 N. M	ORLEY	STREET,	BALT	IMORE,	MD. 2	1229		
	20s. METHOD OF DISPOSITION 11 Buriel 2 Cremetion 3 Remov	rel from State	PLACE AND DATE OF D	ISPOSITION (Na	ne of	DATE	20c. LOC	ATION - City	or Town, Sta	ta	
	4 Donation 5 Other (Specify)		ARBUTUS CE	METERY	1	0-21	-95	ARBUTU	S, MA	RYLA	ND
	21. SIGNATURE OF JUNERAL SERVICE LICE	NSEE		JOSEP	O ADDRESS OF FA H H. BRO W. BALT	J WW	R. FUN	ERAL H	OME, P	.A.	
		11.10		1913	W. BALT	LMORE	ST.,	BALTIM	ORE,	MD.	21223
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	mplications that ceused	the death. Do not	enter the mod	le of dying, aud	h sa card	lac or reapir	atory arrest,		pproxim	
	IMMEDIATE CAUSE (Finel	0. 0.	1 .						10	nterval E Onset an	
	disease or condition resulting in death)	MEIA	SHAML A	renoc	Arano	MA	_		,		
	and the viscol for English with the	DUE TO (OR AS A	CONSEQUENCE OF):	01.0.0	Areino	F	adal.	04014			
8	Sequentially list conditions, b.	DUE TO (OR AS (CONSEQUENCE OF):	ויייול	vy 311	e U	rueje	MINEC			
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	302 10 (011 10 1	CONSCOUNCE OF J.		•						
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			-			-		
HH	resulting in deeth) LAST										
ပ	PART II. Other aignificant conditions	contributing to death h	ut pot reculting in th		ventra annone	Dat I					
CAL	The agricult conditions	Contributing to death b	at not resulting in tr	re underlying	ceuse given in	Part I.	24a. WAS AN A PERFORI	AED?		BLE PRIOR	TO
MEDIC	***					-	1 YES 2	NO	OF DE	ETION DF	CAUSE
	DID TOBACCO USE CONTRI	BLITE TO CALISE O	E DEATH VEC		LINICEDTAL				1 🗆 Y	ES 2 🗌	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (C		UNCERTAI	иПТ					
	EXAMINER?	HOSPITAL:	01	MED.	5 Residence						\rightarrow
Ë	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIME OF	28c, INJL	IRY AT			JURY OCCURE	n		
BY P	1 Netural 5 Pending Investigation	(Month, Day, Year)	INJURY		IK? ES 2 NO						- 1
2	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY building, etc. (Spec	- At home, farm, stree	t, factory, office		28f. LOCA	TION (Street ar	nd Number or Ru	iral Route Nu	mber,	
ш	4 Nomicide determined	building, etc. (Spec	aty)			City o	r Town, State)				
2	29a. CERTIFIER (Check only	AN: To the best of my know	ladge, death occurred at	the time, data	and place, and due	to the caus	e(a) and man	er sa stated.			
COMPLETE		On the basis of examination							se(a) and m	anner as s	tated.
	296. SIGNATURE AND TITLE OF CERTIFIER		· · · · · · · · · · · · · · · · · · ·	Т	29c. LICENSE NUI			29d. DATE SIG			-
2 2	COKEAN	Ry ML				60		▶ Octo			5
2	30. NAME AND ADDRESS OF PERSON WHO CHELLSTOPHELL	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print	20	700 h		BIJP			-	
	31. DATE FILED (Month, Day, Year)	56616 T 13	AURE		<u> </u>				46	30	
	0 . 70 . 1/	HOOLD LTO	•								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

					9/11 6	0.	DEA	• •	NEG. 140.			
l •	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DA	NY	YEAR	3. TIME OF DEATH
	GERT	KIR	SON				OCTOBER 1	.5,19	95	1:25AM M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRT	HPLACE (State or Foreign try)
	219-03-6985A	1 🗆 M 2 🔀 F	75	YRS.	-work (TRIB		HOUNS	wered.	AUG. 2,19	20		RÝLAND
	9s. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH				EATH	9c. COUNTY OF DEATH		
UNECTOR	6968 BROOKMILL RO	DAD, APT.	T-2		BALTIMORE					BALTIMORE		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	ν		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY		
											LIMITS?	
,	MARYLAND BAI 100. STREET AND NUMBER	LTIMORE					BALTIMORE 101. ZIP CODE					1 YES 2 K NO
		מכוג כוג	шэ					WILL COOKING:				
CIVED	6968 BROOKMILL RO	V		T-2 EVER IN U.S. ARMED			21215				JSA	E — American Indian,
- 1	1 Never Married 2 Married	FORCES? 1			lf.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 🏋 NO Specify:			n, Puerto Ricen, etc.)	01110-	Blec	ck, White, etc.
5	3 Widowed 4 Divorced	WH ON DATES		- '	YES	2 DE NO	Specin	r.		Spec	WHITE	
3	15. OECEDENT'S EDU (Specify only highest grade	16a. D	ECEDENT'S	USUAL OC	CUPATI	ON		16b. KIND OF BUS	SINESS/IN	OUSTRY		
	Elementary/Secondary (0-12)	+)	Give kind of ve. Do NOT us	se retired.)	unny mo	OST OF WORK!	19					
	12		HOU	SEWIE	FE			OV	N HC	ME		
COMPLE	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NA	ME (First, Middle, Maiden	Surname)			
. 1	UNKNOWN	G	AMMERMA	N					UNKNOWN			
	19a. INFORMANT'S NAME (Type/Print)								Route Number, City or Tow			
•	MR. YONNIE KIRSON			6968	BROOF	KMII	LL RE	, API	r. T-2 BALT	IMOF	RE, MI	21215
	20a. METHOD OF DISPOSITION 14 Burlal 2 Cremation 3 Ran	noval from State		AND OATE		TION (N	ame of		DATE 20c. LO	CATION -	City or T	fown, Stata
- 1	4 Donation 5 Other (Specify)		В	NAI I	SRAEI				95- BALTIN	ORE,	MD	
	21. SIONATURE OF FUNERAL SERVICE LI	CENSEE	V				ND ADDRE		& BROS., I	ENIC		
	> allens	ul 0	un	400	Ph.				STOWN ROAD		TMOE	RE, MD 21215
	23. PART I. Entar the diseases, or	complications the	it coused the d	leath. Do r								Approximate
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one ce	use on each lin	ie. /	1		0					Interval Between Onset and Death
Ì	disease or condition	11	letas	tex	ric	(dri	ce				4 mos
ł	resulting in death)	DUE TO	(OR AS A CONSI	EOUENCE O	F):		-					
		h										
2	Sequentially list conditiona, if any, leading to immediate	DUE TO	(OR AS A CONSI	IS A CONSEQUENCE OF):								
NI III CANDON	cause. Enter UNDERLYING CAUSE (Disease or injury	c										
	thet initiated events	DUE TO	(OR AS A CONSE	A CONSEQUENCE OF):								
200	resulting in deeth) LAST	d										
	PART II. Other aignificent conditio	ns contributing to	deeth but not	th but not resulting in the underlying ceuse given in Part i,			Part i. 24a. WAS AN	AUTOPSY	24	b. WERE AUTOPSY FINDINGS		
									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									t 🗆 YES 2	Durk		OF DEATH?
	DID TOBACCO USE CONT	RIBLITE TO CA	LISE OF DE	ATH Y	ES II N	JO F	7 IINO	ERTAI	NA			1 TYES 2 NO
	25. WAS CASE REFERRED TO MEDICAL	T T		CE OF DEA				LIVIA				
2	EXAMINER?	HOSPITAL:	FB/Outnetlant	1 - 00A	OTHER	i:	. 10/0	aldana	8 Other (Specify)			
THI SICIAL	27. MANNER OF DEATH	28e. DATE O		28b. TIM			JURY AT	sidence	26d. DESCRIBE HOW I	NJURY O	CCURED	
_	Natural 5 Pending	(Month, i	Day, Year)	IN.	JURY M	W	ORK7 YES 2	NO				
	Accident Investigation 3 Suicide & Could not be		OF INJURY — At h	nome, ferm,	atreet, facto				28f. LOCATION (Street	and Numbi	er or Rural	Route Number,
3	4 Homicide 8 Could not be	building	, etc. (Specify)						City or Town, State)			
	290. CERTIFIER	MOIAN. To she have	Annu benedista a			-						
	(Constant Const								to the cause(s) and ma			(a) and mariner ee stated.
3			TANIMINE TO THE PROPERTY OF TH	riveanganc	on, in my of	pirnori,				ia due to	tne cause	ay and mariner ee stated.
29b. SIGNATURE AND TITLE OF CERTIFIER 29b.							29d. DA	TE SIGNE	D (Mgnth, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CADSE OF DEATH TITEM 27)							DO	16	7 4 4	/	0/10	177
			·			D	m=1	-	.m. 63.666			
	DR. LEONARD KOI			LOWN]	KOAD	BAL	'T.TWO	KE,	WD 51508			
	OCT 1 9 1995	Lia di Lucia	AR'S IGNATURE									
- 1	1 001 - 1000 /	22 14 12 100 a a										



or attending physician. or use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	on, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ecuted within	nd completely	burial, cremati	rtic event, t
rtificate be exe	g physician ar	iene prior to l	ther trauma
the death ce	the attendin	d Mental Hyg	Injury, or o
requires that	en signed by	of Health and	shows any
W: The law	ificate has be	State Dept.	r Item 23 s
ING PHYSICI	After this cert	leath with the	marked, o
OR ATTEND	DIRECTOR: 4	hours after d	Item 28 is
TO THE HOSPITAL	TO THE FUNERAL	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It
-	-	E3	_

	FOR STATE REGISTRAR	STATE OF MARY		MENT OF H		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)		1 -2	- 1-		A DATE OF DEATH		3. TIME OF DEATH
	MBLVIN	G. 1	ENN	12 %		MONTH DA	7,1995	7:40A M
			(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH	0.00	RTHPLACE (State or Foreign untry)
	213 10 3/31		74 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Nov 10,19	20	Md
_	Se. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN (R LOCATION OF DE		9c. COUNTY OF	DEATH
0	Church Hospital			Balti	more		N/	A
E G	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			10d, INSIDE CITY
DIRECTOR	Md Balti	more		undalk				LIMITS?
	10e. STREET AND NUMBER			101	ZIP CODE		10a, CITIZEN O	1 YES 2 NO
FUNERAL	81 Dundalk Avenue				21222		USA	
5		12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yee	or No.— 14, R/	ACE — American Indian,
BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 X YES			colfy Cuben, Mexicer 2 NO Specify	n, Puerto Rican, etc.)		ack, White, atc.
								white
COMPLETED	15, DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	18a, DECEDENT'S U (Give kind of wo life, Do NOT use	ork done durina ma	IN st of working	16b. KIND OF BUS	INESS/INDUSTRY	′
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)						
MO	17. FATHER'S NAME (First, Middle, Last)		Moving &	naulin		Fed. ME (First, Middle, Maiden S	Govern	ment
Ö	Harry Kenney					ta Deal	surneme)	- 1
BE (19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e		la Deal	Stets. Zin Code)	
5	Helen Kenney					lk, Md. 21:		
	20e. METHOD OF DISPOSITION 1 © Burlel 2 □ Cremation 3 □ Remove		b. PLACEAND DATEO	DISPOSITION (Na			CATION — City or	Town, State
	4 Donation 8 Other (Specify)		netery, crematory or oth loly Redee	mer Cem	etery	10/20 Bal	to. Md.	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AN	D ADDRESS OF FAC	CILITY		
	Titler	on Ida	1100			n Funeral I		11 1/1 01000
	23. PART I. Enter the diseases, or co	mplications that cause	d the death. Do no	ot enter the mo	de of dying, such	ss cardiac or reapir	atory arreat,	1k Md 21222
	shock, or heert fellure. Li IMMEDIATE CAUSE (Fine)							Interval Between Onset and Death
	disesse or condition resulting in death)	CHRONIC DUE TO (OR AS	013571	COCTI	EPL	ULMONI	ARV	YEARS
İ		DUE TO (OR AS	A CONSEQUENCE OF)	:	DIS	6456	7	1000
N	Sequentially list conditions, b.					- 17 5 2		
AT	if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF)					
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF)					
CERTIFICATION	resulting in death) LAST							
	DATY II Other significant as dele-							
MEDICAL	PART II. Other significant conditions			the underlying	cause given in f	Part I. 24s. WAS AN / PERFORI		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	- 176A/CT	PAIL	0/2/12			1 YES 2	NO NO	OF DEATH?
M	DID TODA CCO LICE COA ITAL	21177 70 644467					- 1	1 _ YES 2 _ NO
PHYSICIAN:	DID TOBACCO USE CONTRI	BUTE TO CAUSE (26. PLACE OF DEATH		UNCERTAIN			
S S	EXAMINER?	HOSPITAL:		OTHER:				
¥	27. MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME		8 Residence	8 Other (Specify) 28d. DESCRIBE HOW IN	IIIDY OCCUPED	
	1 Netural 5 Pending	(Month, Day, Year)	INJU	NO YR	RK?	and begoning now in	SONT OCCURED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, ferm, at	reet, fectory, office		28f. LOCATION (Street or	nd Number or Run	if Route Number,
	4 Homicide determined	bunding, att. (ope	icity)			City or Town, State)		
COMPLETED	29e. CERTIFIER (Check only	AN: To the best of my know	vledge, dsath occurred	at the time, date	end place, end due I	to the couse(e) and mann	ner es atated.	
MO		On the besis of examination						e(s) end manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d DATE SIGN	FD (Month Day Vee)
D BE	An Proven	m' m	0		0173	22	> oct	.17.1995
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI	EATH (ITEM 27) (Type, F	Print) VRCH	HOSP	ITAL - 1	3107	21231 MD
	31. DATE FILED (Month Day Year)	32. REGISTRANG SIGN	ATURE		01-11	111-11	11-1-	(-11)
	70.2 1000				_			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

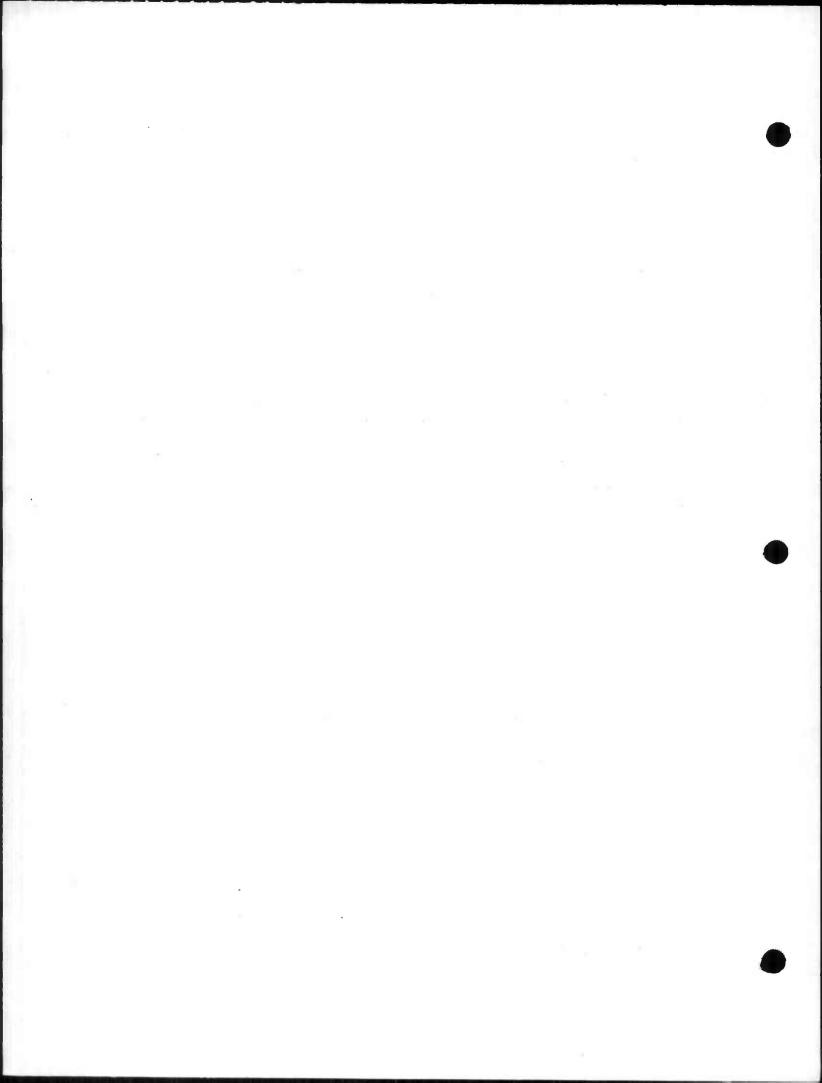
ITEMS: 23 PART I, 27, PER MEO FILM G-728 10/20/95 t.t

				LNIII	ICATE OI		Τ.	REG. NO.		-		
PATRICK	t, Middle, Last) Law	son	KENI	NEDY			MONTE	OF DEATH DA		YEAR 995	9:40	
4. SOCIAL SECURITY NUM 213-68-2397		5. SEX 1	6. AGE (In yrs.)	last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH , Day, Year) 24,19		8. BIRTH Country	PLACE (State or F	oreign
9a. FACILITY NAME (# not)	institution, give s	street and number)			9b. CITY, TOWN	OR LOCATION OF D		.,,	9c. COUN	TY OF DE	EATH	_
ST. AGNE	S HOS	PITAL	_		BAL:	TIMORE (CITY			N/A		
Md	Bal	v timore		10c. CIT	Gwynn						10d. INSIDE CIT LIMITS? 1 XYES 2	
970 Masef		oad				01. ZIP CODE 21207			10g. CITIZ	US A	HAT COUNTRY?	
11. MARITAL STATUS 1 Never Merried 2 3 Wildowed 4 Div		12. WAS DECEDENT FORCES? 1 IF YES, GIVE V	YES 2 MAR OR DATES		If yes,	ECENDENT OF HISPA specify Cuben, Maxie S 2 NO Speci	an, Puerto f		or No—	Specif	— American ind , White, etc. /y: vhite	an,
	CEDENT'S EDU	CATION	16e, I	DECEDENT'S	USUAL OCCUPAT	TION	16b.	KIND OF BU	SINESS/INDL		VIIICC	
Elementary/Secondary (College (1-4 or 5		lile. Do NOT us	te Sale			S	ales			
17. FATHER'S NAME (First, I	Middle, Last)	<u>-</u>		nou	cc bare	18. MOTHER'S N.	AME (First, I					_
Eugene B.	Kenne	dy				Patri	cia l	Doughe	rtv			
19a. INFORMANT'S NAME				19b. MAJLINO	ADDRESS (Stree	and Number or Rural				Code)		
Susan Kenne	dy			970 1	Masefie	ld Road,	Balte	o, Md.	212	07		
20a. METHOD OF DISPOSI 1 Burlai 2 Koremati 4 Donation 5 Othe	ion 3 🗆 Rsm	noval from State	20b. PLAC Ches	EANDDATE	OF DISPOSITION (Name of	DAT	20c. LO	CATION — C			
4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and address o								10/17 Beltsville, Md.				
23. PART I. Enter the	diseases, or	ash			Ster 736		on Fu	nue. B	alto.	Md.	21228 Approximinterval I	
23. PART I. Enter the shock, or iMMEDIATE CAUSE (Fidisese or condition resulting in death) Sequentielly list conditioning any, leading to immediate the shock of	diseases, or heart feilure.	complications the List only one can DUE TO ATHERO	ARY ARTER	THRONSEQUENCE OF	Ster 736 not enter the n 4BOSIS FI: IOVASCULA	ling Asht Edmondsor	on Fu	nue. B	alto.	Md.	Approxim	etwe
23. PART I. Enter the shock, or iMMEDIATE CAUSE (Fidsesse or condition resulting in death) Sequentially list conditional cond	diseases, or heart fellure. inal	CORONA BUE TO C.	ARY ARTER O (OR AS A CONS OSCLEROTI	Y THRON BEQUENCE OF C CARD	Ster 736 not enter the n MBOSIS F): IOVASCULA	ling Asht Edmondsor node of dylng, au	on Fu	nue. B	alto.	Md.	Approxin	etwe
23. PART 1. Enter the shock, or immediate CAUSE (Fidisess or condition resulting in death) Sequentially list cond if any, leading to immicials. Enter UNDERLY CAUSE (Disesse or in that initiated events resulting in death) LA: PART II. Other significations.	diseases, or heert fellure. inal heediste YING lury ST	a. CORONA B. DUE TO C. DUE TO	ARY ARTER D (OR AS A CONS OSCLEROTI D (OR AS A CONS O (OR AS A CONS	Y THRON SEQUENCE OF C CARD. SEQUENCE OF SEQUENCE OF	Ster 736 not enter the n MBOSIS F): IOVASCULA F):	Ling Asht Edmondsor node of dylng, au R DISEASE	AVE	nue. B	AUTOPSY	Md.	Approxin	TINDING TO CAUSE
23. PART I. Enter the shock, or immediate CAUSE (Fidsesse or condition resulting in death) Sequentielly list condition in the cause. Enter UNDERLY CAUSE (Disesse or in that initiated events resulting in death) LA: PART II. Other signification of the cause in the	disease, or heart fellure. inal itions, ediate ying lury st	a. CORONA B. DUE TO C. DUE TO	ARY ARTER O OR AS A CONS O SCLEROTI O OR AS A CONS O OR AS A CONS O OR AS A CONS	Y THROM SEQUENCE OF C CARD SEQUENCE OF SEQUENCE OF t resulting	Ster 736 not enter the n HBOSIS F): IOVASCULA F): In the underly	Ling Asht Edmondsor node of dylng, aud R DISEASE	AVE	Pilsc or responded to the second seco	AUTOPSY	Md.	Approxininterval II Onset an Onset an WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH?	etweed Dea
23. PART 1. Enter the shock, or immediate CAUSE (Fidisease or condition resulting in death) Sequentielly list cond if any, leading to immicause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA: PART II. Other significations.	disease, or heart fellure. inal itions, ediate ying lury st	a. CORONA B. DUE TO C. DUE TO	ARY ARTER O OR AS A CONS O SCLEROTI O OR AS A CONS O OR AS A CONS O DO OR AS A CONS O DO DO DO DO DO DO DO DO DO DO DO DO DO	Y THRON BEQUENCE OF C CARD. BEQUENCE OF DEATH YELL ACE OF DEATH	Ster 736 THOUSIS FINITE THE UNDER STEP STEP STEP STEP STEP STEP STEP STEP	Ling Asht Edmondsor node of dylng, aud R DISEASE	AVE	24e. WAS AN PERFOI	AUTOPSY	Md.	Approxininterval II Onset an Onset an WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH?	TINDING TO CAUSE
23. PART I. Enter the shock, or immediate CAUSE (Fidsesse or condition resulting in death) Sequentielly list condition resulting in death) Sequentielly list condition resulting in death) CAUSE (Disesse or in that initiated events resulting in death) LA: PART II. Other signification of the condition of the c	diseases, or heert fellure. inal hitions, ediate fring lury ST USE CONT TO MEDICAL	CORONA a. CORONA DUE TO c. DUE TO d. RIBUTE TO CA HOSPITAL: 1 Imperiant 2 280. DATE OF	ARY ARTER D (OR AS A CONS O SCLEROTI D (OR AS A CONS D (OR AS A CONS D (OR AS A CONS D (OR AS A CONS	THROM SEQUENCE OF C CARD. SEQUENCE OF CARD. Tresulting EATH YILL ACE OF DEA 3 X DOA 28b. Tim	Ster 736 MBOSIS F): IOVASCULA F): In the underly TH (Check only or OTHER: 4 Nursing H. BE OF 26c. I	Ling Asht Edmondsor node of dylng, sur R DISEASE	AVE) the as core	24e. WAS AN PERFOI	Alto, iratory sirre	Md	Approxininterval II Onset an Onset an WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH?	d Dea
23. PART I. Enter the shock, or immediate CAUSE (Fidsesse or condition resulting in death) Sequentielly list condition resulting in death) Sequentielly list condition resulting in death) CAUSE (Disease or in that initiated events resulting in death) LA: PART II. Other signification of the condition of the c	diseases, or heert fellure. inal hittons, ediate fillury structury structury to MEDICAL	CORON/ a. CORON/ DUE TO c. DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. PLACE 0	ARY ARTER O OR AS A CONS O SCLEROTI O OR AS A CONS O OR AS A CONS O DO OR AS A CONS O DO DE CONS O DE CONS	Y THROM SEQUENCE OF C CARD. SEQUENCE OF The resulting EATH YI ACE OF DEA 28b. TIM IN.	Ster 736 MBOSIS F): IOVASCULA F): In the underly TH (Check only or OTHER: 4 Nursing H. HE OF JURY M 1	Ling Asht Edmondsor node of dylng, au R DISEASE Ing ceuse given in UNCERTA e) ome 5 Raeldence NJURY AT YORK? YES 2 NO	AVE OTHER PART I.	24e. WAS AN PERFOI	Alto, iratory sired	Md	Approxininterval E Onset an On	TINDING TO CAUSE
23. PART 1. Enter the shock, or immediate CAUSE (Fidisesse or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or in that initiated events resulting in death) LA: PART II. Other signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the significant of the	diseases, or heert fellure. inal heert fellure. inal heert fellure. Itions, ediate fillure fellure. Itions, ediate fillure fillure. Itions, ediate fillure. Itions fillure fellure. Itions fillure fellure. Itions fillure fellure. Itions fillure fellure. Itions fillure fellure. Itions fillure fellure. Itions fillure fellure. Itions fil	CORONA B. DUE TO C.	ARY ARTER O OR AS A CONS O SCLEROTI O OR AS A CONS O OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O OR AS A CO	Y THRON SEQUENCE OF C CARD. SEQUENCE OF SE	Ster 736 THOUSIS FINITE STEP STEP STEP STEP STEP STEP STEP ST	Ling Asht Edmondsor node of dylng, such R DISEASE Ing ceuse given in UNCERTA e) Dome 5 Residence VORK? YES 2 NO Itics	AVE OTHER ASSESSED OF THE ASSE	24e. WAS AN PERFOI 1 VES 2 T (Specify) ATION (Street or Yown, State, see(a) and ma	AUTOPSY RMED? E NO INJURY OCC and Number	Md	Approxininterval interval interval interval in Onset and	etweed Dead
23. PART 1. Enter the shock, or immediate CAUSE (Fidisesse or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or in that initiated events resulting in death) LA: PART II. Other signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the significant of the	diseases, or heert fellure. inal heert fellure. inal heert fellure. It inal heert fellure.	CORONA a. CORONA DUE TO ATHERO DUE TO C. DUE TO d	ARY ARTER O OR AS A CONS O SCLEROTI O OR AS A CONS O OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O DO OR AS A CONS O OR AS A CO	Y THRON SEQUENCE OF C CARD. SEQUENCE OF SE	Ster 736 THOUSIS FINITE STEP STEP STEP STEP STEP STEP STEP ST	Ling Asht Edmondsor node of dylng, aud R DISEASE Ing ceuse given in UNCERTAL e) one 5 Residence NJURY AT YORK? YES 2 NO lice ste and place, and du , death occured at the	AVE TO THE AME TO THE	24e. WAS AN PERFOI 1 VES 2 T (Specify) ATION (Street or Yown, State, see(a) and ma	I AUTOPSY MAED?	Md	Approxininterval is Onset an O	etweed Dea
23. PART 1. Enter the shock, or immediate CAUSE (Fidisease or condition resulting in death) Sequentielly list condition resulting in death) Sequentielly list condition resulting in death) CAUSE (Disease or in that initiated events resulting in death) LA: PART II. Other signification of the condition of the	diseases, or heert fellure. inal heert fellure. inal heert fellure. It inal heert fellure.	CORONA a. CORONA DUE TO ATHERO DUE TO C. DUE TO d	ARY ARTER O (OR AS A CONS O SCLEROTI O (OR AS A CONS O (OR AS	THROM SEQUENCE OF C CARD. SEQUENCE OF SEQUENCE OF DEA 28b. TIM IN. home, farm, death occurr or investigation	Ster 736 The content of the not enter the n	Ling Asht Edmondsor node of dylng, such R DISEASE Ing ceuse given in UNCERTA e) Dome 5 Residence VORK? YES 2 NO Itics	AVE OTHER PART I. 6 OTHER 28d. DES	24e. WAS AN PERFOI 1 VES 2 T (Specify) ATION (Street or Yown, State, see(a) and ma	AUTOPSY RMED?	24b.	Approxininterval interval interval interval in Onset and	etweed Ded

FOR STATE REGISTRAR 1 -

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DEA			3. TIME OF DEATH
	Mabel	W		Kam	zura					Octobe	C 16.	995	19:42 PM
	4. SOCIAL SECURITY NUMBER 216-24-5482 1 M 2 F 67 9a. FACILITY NAME (If not institution, give street and number)					IF UNDER			7	7. DATE OF BIRT	ГН	8. BIRTI	HPLACE (State or Foreign
						MONTHS	DAYS	HOURS	MIN.	July 2	2,1928	Count	"Md
	9a. FACILITY NAME (If not in	stitution, give a	treet end number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE		-	UNTY OF E	DEATH
DIRECTOR	Bayview Medical Center					В	alt	imore				N/A	
E I	10e. STATE	10b. COUNTY	,		10c. CITY, TOWN OR LOCATION					10d. IN			10d. INSIDE CITY
	Md	Balt	imore]	Dund	a1k						LIMITS? 1 X YES 2 NO
Z I	10e. STREET AND NUMBER						1	101. ZIP COD	-		10g. C		WHAT COUNTRY?
ᇤᅵ	6735 Woodle	y Road						2122	2			USA	
BY FUNERAL	11. MARITAL STATUS 1 Never Metried 2 🔀 3 Widowed 4 Divo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 X			If yes,		en, Mexica	NIC ORIGIN? (Specin, Puerto Rican, e y:			E — American Indian, k, White, etc. //y: White
유	15, DEC	EDENT'S EDU	CATION		ECEDENT'S					16b. KIND	OF BUSINESS/I	NDUSTRY	WALLE
	Elementary/Secondary (f	y highest grade 3-12)	College (1-4 or 5 +	566	Do NOT us	e retired.)	auring i	most of world	ng				
릴	12		1		Cleri					Ho	ospital	L	
COMPLETED	17. FATHER'S NAME (First, M							te. MOT	HER'S NA	ME (First, Middle, I	Veiden Surname)	
<u></u>	Sidney Webs	ter						V	idet	te Hall			
) BE	19e. INFORMANT'S NAME (. 19						Route Number, City			
임	Leroy Kamzu	ra			6735	Wood	dle	y Roa	d, D	undalk,	Md. 21	222	
	20e. METHOD OF DISPOSIT 1 M Burlel 2 □ Cremete 4 □ Donation 5 □ Other	on 3 🗆 Rem	oval from State	20b. PLACE cemetery, cr		ther place)		(Name of		10/20	Balti		
	21. SIGNATURE OF FUVERA		ENSEE	Ua	KJAWI	22.		AND AOORE					
	1	1 - 5	()-0-	h No	0.11			-		n Funera			
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cerdisc or respiratory errest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								54 costs				
B		-	d										
MEDICAL	PART ii. Other significent conditions contributing to deeth but not resulting in the underly						underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO			Y 24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ä	DID TOBACCO L	JSE CONT	RIBUTE TO CA						CERTAI	ИП			
CE	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HQSPITAL:	26. PLA	CE OF DEA	TH (Check		ne)					
Z	1 TES 2 NO		1 Inputient 2	ER/Outpetient	3 DOA			lome 5 🗆 R	Residence	6 Other (Spec	ify)		
PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5		28e. DATE OF (Month, D		26b. TIN	IE OF JURY M		INJURY AT WORK?	□ NO	28d. DESCRIBE	HOW INJURY	OCCURED	
TED BY	1 SNatural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined					street, tac	ctory, a			261. LOCATION City or Town		nd Number or Rural Route Number,	
COMPLETED	Crieck brity		ICIAN: To the best of										(e) end menner ee stated.
			-				,						
BE	29b. SIGNATURE AND TITL	e or centrig	To mo					-	CENSE NU				D (Month, Day, Year)
2	30. NAME AND ADDRESS O	MALLY V	V	SE OF SEATH	Eu en e	- Out-of		1 1	00,	100	(Octob	er 16, 1995
	Joshua		NOMO 40	MD (IT	John	5 H	opk	ins t	050	tel, B	attino	re , 1	MD 21045
	31. DATE ELLED (MONTH, Day	95	3 RECKSTR	AR'S GNATURE									



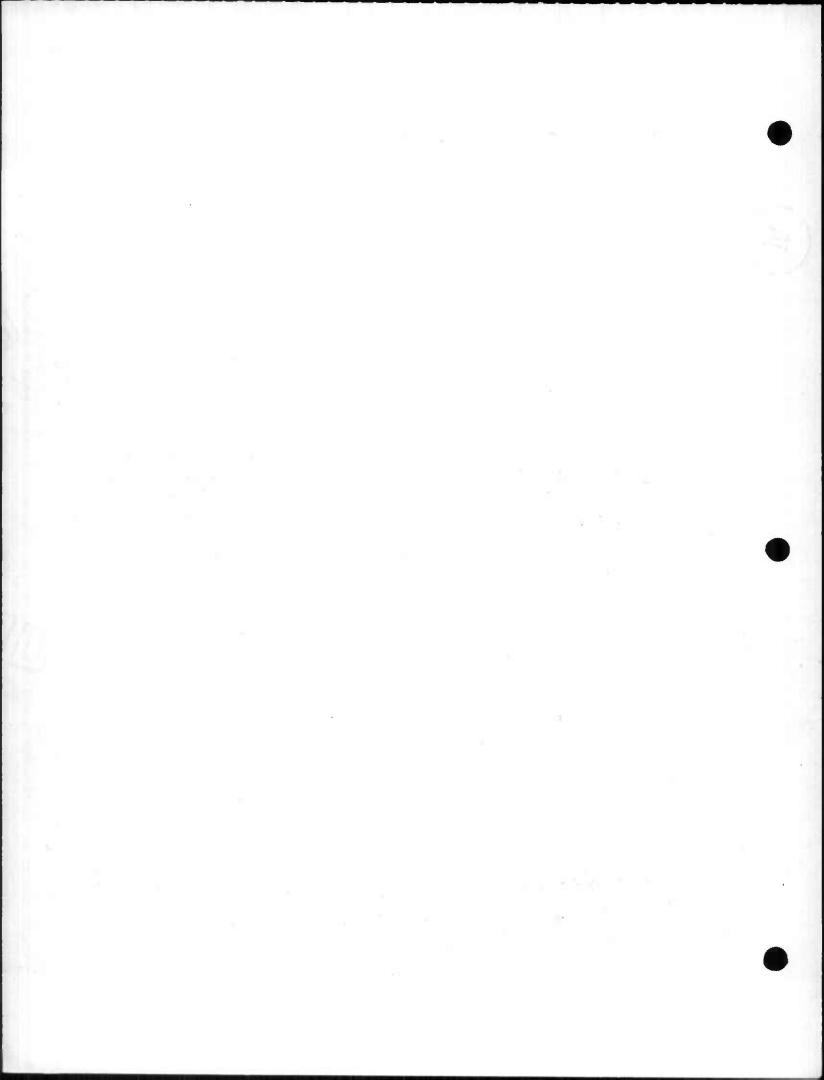


DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	s after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-trail be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	by the funeral director, page 5 should be detached for use as the burial-trail removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	dical examiner must be notified at once.

	FOR STATE REGISTRAR		STATE OF W
	1. DECEDENT'S NAME (First,		-100
	SANDRA 4. SOCIAL SECURITY NUMBER		5. SEX
	394-42-109		1 M 2 OF
	90. FACILITY NAME (If not in	stitution, give str	eet end number)
5	University	y Hospi	tal
5	RESIDENCE OF DEC	10b. COUNTY	
	Maryland		Arundel
	10e. STREET AND NUMBER		
FUNERAL DIFECTOR	2657 April I	Dawn Wa	У
5	11. MARITAL STATUS 1 Never Merried 2.X	Married	12. WAS OECEDEN FORCES? 1
-	3 Widowed 4 Divo	Control of the Contro	1 061 -
_		EDENT'S EDUC	
	(Specify onli Elementary/Secondary (6	y highest grade o	College (1-4 or 5 +
			4
O DE COMPLETED	17. FATHER'S NAME (First, M		
4	"Unavai1		reston
2	Gregory C.	ypa/Print) Lange	
	20e. METHOD OK DISPOSIT	ION on 3 🗆 Remo	val from State
	4 Donation 8 Other	(Specify)	
	21. SIGNATURE OF THERA		
	George	E. Ma	cNabb
	23. PART I. Enter the d ahock, or h		omplications tha lat only one ceu
	IMMEDIATE CAUSE (Fit	nei	M-
	resulting in death)	7 ,	DUE TO
5	0		DIF
5	Sequentially list condit		DUE TO

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
		CE	RTIFICATE	OF	DEAT	TH		REG.	NO.

REGISTRAR		CERTIFIC				G. NO.			
1. DECEDENT'S NAME (First, Middle, Last	0				2. DATE OF DI	EATH DAY	YEAR	3. TIME OF D	EATH
SANDRA	STARR	LANGE			Oct.	15	95	1:25	PM
4. SOCIAL SECURITY NUMBER 394-42-1097	1 🗆 M 2 🞾 F	52 YRS.	F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		3, 1943	Wis	consin	or Foreign
90. FACILITY NAME (If not institution, give University Hospitalian Property Hospitalian Prope		9	Balti	more	EATH		A	DEATH	
10a, STATE 10b. COUN		10c. CITY, 1	TOWN OR LOCAT	ION		1.1.2.1		10d. INSIDE (CITY
Maryland Ani	ne Arundel		Gambri1	.1s				1 TYES 2	23
2657 April Dawn				210			US		
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EN FORCES? 1 X IF YES, GIVE WAR 1961 -	YES 2 NO OR DATES	If yee, spe	ENDENT OF HISPAI ecity Cuben, Mexica 2 NO Specifi	n, Puerto Rican,			E — American k, White, etc.	
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	rk done during mo: retired.)	ON si of working		OF BUSINESS/II			
	4	Business	Owner			nercial		ning S	ervic
"Unavailable"	Preston			16. MOTHER'S NA	we (First, Middle,				
190. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Route Number, Ci	ity or Town, State, i			
Gregory C. Lan	ge	2657 A ₁	pril Da	wn Way	Gambri]	lls, MD	2105	4	
20e. METHOD OKOISPOSITION 1 Buriel 2 Cremetion 3 Re 4 Donation 8 Other (Specify)		20b. PLACE AND OATE OF Metro Cremi	atroy,	Inc. 10/	17/95	Balti	more	, MD	
21. SIGNATURE OF THERAL SERVICE		W/	crema	tion Soc	elety o	f Maryla	and,	Inc.	
George E. M. 23. PART I. Enter the diseases, of ahock, pr heart failur IMMEDIATE CAUSE (Finel disease or condition resulting in death)	or complications that co e. List only one ceuse	on each line.	enter the mo		h as cardlec	or respiratory	errent,	Appro intervi Onset	
23. PART I. Enter the diseases, of ahook, Dr heart failur IMMEDIATE CAUSE (Finel disease or condition	a. MET BUE TO (OF		enter the mo	de of dying, suc	h as cardlec	or respiratory	errent,	Appro intervi Onset	I Batween
23. PART i. Enter the diseases, on ahock, or heart failur immediate cause or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. MET BUE TO (OF C. OUE TO (OF	ASTATTE RAS A CONSEQUENCE OF: RAS A CONSEQUENCE OF:	SATURALA	LEAST	CAN R COI	WAS AN AUTOPS PERFORMED?	HTDO	Approinterve Onset	al Batweer and Death
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23. PART i. Enter the diseases, on ahock, Dr. heart failur immediate cause or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions.	a. MET BUE TO (OF C. OUE TO (OF d. HOSPITAL:	ON EACH IINE. A S TATTE R AS A CONSEQUENCE OF): R AS A CONSEQUENCE OF): R AS A CONSEQUENCE OF): Other but not resulting in SE OF DEATH YES 26. PLACE OF DEATH	the underlying	SEAST CULP g cause given in	Part I. 24a.	WAS AN AUTOPS PERFORMED?	HTDO	Approinterve Onset	and Death and Death sy Findings sy Findings sion to of cause
23. PART i. Enter the diseases, or shock, or heart failur immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of the condi	a. MET BUE TO (OF B. DUE TO (OF C. OUE TO (OF d. ITRIBUTE TO CAUS HOSPITAL: 1 Dispettent 2 = E1 28e. OATE OF IN. (Month, Dey.	ON EACH INE. A S TATT B AS A CONSEQUENCE OF: A AS A CONSEQUENCE OF: B AS A CONSEQUENCE OF: CONSEQUENCE	the underlying (Check only one) THER: Nursing Horn OF 28c. INV	S CULPA g cause given in UNCERTAL	Part I. 24a.	WAS AN AUTOPS PERFORMED?	Y 24	Approinterve Onset	and Death and Death sy Findings sy Findings sion to of cause
23. PART i. Enter the diseases, or shock, or heart failur immediate CAUSE (Finel disease or condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death LAST DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	a. MET BUE TO (OF DUE TO (OF C. OUE TO (OF DUE TO	ASTATTER AS A CONSEQUENCE OF): R AS A CONSEQU	the underlying (Check only one) THER: Nursing Hom OF 28c. INJ. RY M 1	Ge of dying, such that the same	Part I. 24a. Other (Spot 28d, DESCRIB	WAS AN AUTOPS PERFORMED? YES 2	Y 24	Approintervi Onset b. WERE AUTOP AMALABLE PI COMPLETION OF DEATH? 1 YES 2	and Death and Death sy Findings sy Findings sion to of cause
23. PART i. Enter the diseases, or shock, or heart failur immediate CAUSE (Finel disease or condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death last initiated events resulting in death) LAST DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	a. MET BUE TO (OF DUE TO (OF	ASTATTER AS A CONSEQUENCE OF): R AS A CONSEQU	the underlying (Check only one) THER: Nursing Hom No Each Nursing Hom THER: Nursing Hom THER: THER	Ge of dying, such that the second of the sec	Part i. 24a. Other (Spi 28d, DESCRIB 28f, LOCATION City or To	WAS AN AUTOPS PERFORMED? YES 2 ON (Street and Number), State) and menner as a	Y 24-	Approintervi Onset b. WERE AUTOP AMILABLE PI COMPLETION OF DEATH? 1 YES 2	sy Findings side to of Cause
23. PART i. Enter the diseases, or shock, or heart failur immediate CAUSE (Finel disease or condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death last initiated events resulting in death) LAST DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	a. MET BUE TO (OF DUE TO (OF C. OUE TO (OF DUE TO	AS TATTER AS A CONSEQUENCE OF: R AS A CONSEQUENCE OF:	the underlying (Check only one) THER: Nursing Hom No Each Nursing Hom THER: Nursing Hom THER: THER	Ge of dying, such that the second of the sec	Part I. 24a. Color Color	WAS AN AUTOPS PERFORMED? YES 2 ON (Street and Number, State) Pend menner as a place, and due to	y 24	Approintervi Onset b. WERE AUTOP AMALABLE PI COMPLETION OF DEATH? 1 YES 2 Route Number, (e) and menner	al Batweer and Daati Sy Findings Sy Findin
23. PART i. Enter the diseases, or shock, Dr heart failur immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of the condi	a. MET DUE TO (OF	OF DEATH (ITEM 27) (Type, F	the underlying (Check only one) THER: 10 Nursing Hom OF RY M 1 1	BS CLAUP BS CLA	Part I. 24a. Part I. 24a. S Other (Spot 28d. DESCRIB) 28f. LOCATION City or Town a to the cause(e) of time, date and	WAS AN AUTOPS PERFORMED? VES 2 BOOK OF THE PROPERTY OF THE PR	Y 24-	Approintervi Onset b. WERE AUTOP AMALABLE PI COMPLETION OF DEATH? 1 YES 2	as stated.
23. PART i. Enter the diseases, or shock, or heart failur immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death Last DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	a. MET DUE TO (OF	OF DEATH (ITEM 27) (Type, F	the underlying (Check only one) THER: 10 Nursing Hom OF RY M 1 1	BS CLAUP BS CLA	Part I. 24a. Part I. 24a. S Other (Spot 28d. DESCRIB) 28f. LOCATION City or Town a to the cause(e) of time, date and	WAS AN AUTOPS PERFORMED? YES 2 ON (Street and Number, State) Pend menner as a place, and due to	Y 24-	Approintervi Onset b. WERE AUTOP AMALABLE PI COMPLETION OF DEATH? 1 YES 2 Route Number, (e) and menner	as stated.



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	hours

DIVISION OF VITAL RECORDS, P.O. BOX 68760

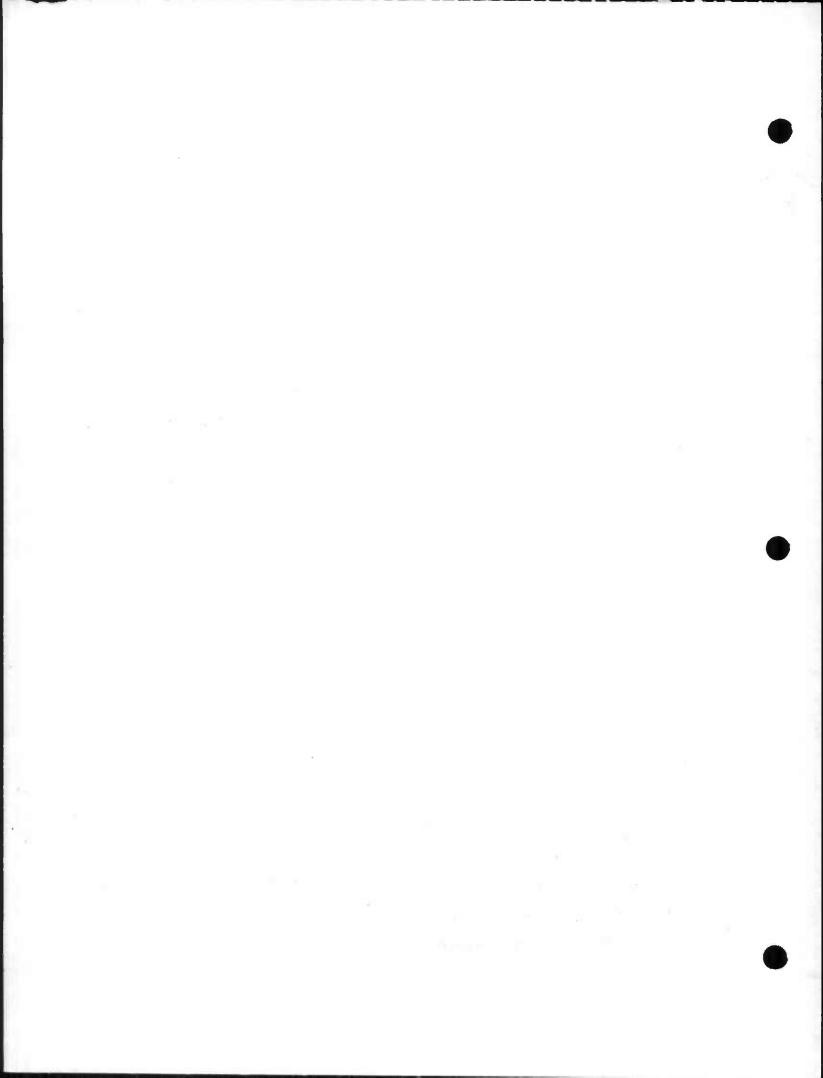
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit is be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

	TIEGIG TTENT		-		1407 11 100	-	to he ra			HUG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE OF MONTH	DEATH	~	YEAR :	3. TIME OF DEATH
	Myrtle 4. SOCIAL SECURITY NUMBER		Lee						Octob	er 13		95	4:00 P M
		5. SEX	6. AGE (In yrs. la		IF UNDER 1	DAYS	HOURS	MIN.	7. DATE OF (Month, D			Country)	LACE (State or Foreign
	216-20-5457	1 - M 2 X F	83	YRS.					Aug 3	0, 19	12	Mar	yland
	Sa. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, T	OWN O	R LOCATI	ON OF DE	ATH		9c. COU	NTY OF DEA	ATH
R	1190 West Norther	n Parkway	7			Ba	1tim	ore				n/a	1
DIRECTOR	RESIDENCE OF DECEDENT			I									
2	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR	LOCAT	ION					'	IOd, INSIDE CITY LIMITS?
		/a		<u> </u>	Balt	imo	re						YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101.	ZIP COD	E			10g. CIT	IZEN OF WH	IAT COUNTRY?
E	1190 West Norther	n Parkway	7				2	1210)			USA	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AI						IIC ORIGIN7 (or No-	14. RACE -	- American Indian, White, etc.
	1 Never Married 2 Married	IF YES, GIVE W		NO				Specify		in, etc.)		Specify	
B	3 Widowed 4 Divorced		111.4 101.30										Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a, Di	ECEDENT'S	USUAL OCC	UPATIC	ON st of worki	no	16b. KI	NO OF BUS	INESS/INI	DUSTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +	- 46	. Do NOT u	se retired.)			1.5					
릴		4+		Tea	cher				Ba	lto C	ity	Publi	c Schools
ő	17. FATHER'S NAME (First, Middle, Lest)			-			16. MOT	HER'S NA	ME (First, Mid	dle, Maiden	Surname)		
	Adam Nash						Mag	aie	Smith				
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street a			Route Number,	City or Town	n. State, Zij	p Code)	
2	Bonda Lee-Cunnin	aham		283 M	arlbo	ro	Road		Brook	lvn.	New	York	11226
	20a, METHOD OF DISPOSITION	5,000			OFDISPOSIT				OC ^{PATE}			City or Tow	
	1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, cr	emetory or o	emori	- 1	Davele						unty, MD
	21. BISMATURE OF UNERAL SERVICE LIE	семен	Jacour	Jus P	22. N	AME AN	D ADDRE	SS OF FA	CILITY MIT	tter	Fune	ral F	lomes, Inc.
	11.11	h.	1 . +	1					Falls				iomes, inc.
	haver.	IW.X	nell	2	В	alt	imor	e, M	aryla	nd 2	1216	,	
	23. PART I amer the diseases, or shock, or heart failure.				not enter t	he mo	da of dy	ing, suc	h as cardia	c or reapl	ratory ar	rest,	Approximata Intarval Between
	IMMEDIATE CAUSE (Final	4 A 1	1 1.						~				Onest and Death
	disease or condition resulting in death)	Meda	static	b	reas	+	ca	nci	non	~			onemont
	reauting in death)	DUE TO	(OR AS A CONS										
_	-												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE C	F):								
Y	cause. Enter UNDERLYING												
Ē	CAUSE (Disease or Injury that initiated evente	DUE TO	(OR AS A CONSI	EOUENCE C	F):								
	resulting in death) LAST	d.											
			Total Land						5				
EDICAL	PART II. Other algorificant condition	na contributing to	death but not	reaulting	in the und	arlyln	g cause	givan in	Part I. 2	4a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
8									— II	YE8 2	XNO		COMPLETION OF CAUSE OF DEATH?
ME									_		,		1 NES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗌 N	o D	UN	CERTAII	N 🗆				
X	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL/	CE OF DE	TH (Check or								
Sic	1 TES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	4 Nursi	ng Hom	10 5 XR	lasidence	8 🗆 Other (S	Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF		28b. TII	WE OF		URY AT		28d. DESCI	RIBE HOW I	NJURY O	CURED	
	Natural 5 Pending	(Month, E	rey, reer)	"	M		YES 2	□ NO					
ВУ	Z Accident 3 Suicide 8 Could not be		F INJURY — AI I	ome, farm,	street, facto	ry, offic	•					or or Rural Ro	oute Number,
COMPLETED	4 Homicide determined	building,	atc. (Specify)						City or	Town, State)			
	29a, CERTIFIER							- 50.75	1000000		-1200		
MP	(Check only 1 CERTIFYING PHYS	SICIAN: To the best of											CONTROL TOWARD
Ö	2 MEDICAL EXAMIN	ER: On the basis of a	IXE///INEEEON ENG/O	rinvestigat	ion, in my op	inion, c	Matth occi	ured at the	Hime, Oata at	na piaca, ar	id dua 10 i	ine cause(a)	and manner as stated.
ш	29b BIGNATURE AND TITLE OF CERTIFIE	in C					29c, LIC	CENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
0 8	Marstrul (1c	Xm	e				1	148	5+5			10/19	195
5	30. NAME AND ADDRESS OF PERSON WI	partie.	SE OF OEATH (IT	EM 27) (Typ	e, Print)		n	./	Bal	di.		MIN	21209
	111111111111111111111111111111111111111	vine.	4000	010	2 (01	101	- 1	a.	Wal	Juno	la j	JID	21208
	31. DATE FILEO (Month, Day, Year)	32. REGISTRA	AR'S SIGNATURE										
	OCT 1 9 1995 A	THE WHAT	The Well										



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After	death	S ma
CTOR	s after	28
DIRE	hours	item
VERAL	hin 72	NT: If
IE FU!	DIM DI	NTTA!
TH OT	be file	IMPC
	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

							9	U	5 1 4 2 4
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMEN ERTIFICAT			NTAL HYGIEN REG. NO.	E		
	DECEMENT'S NAME (First, Middle, Last)	Lyde			2	CTOOK	6 199	AR A	ME OF DEATH 530 M
	212-34-2538 se. FACILITY NAME (If not institution, give st		6 YRS. MONTHS	DAYS HOL	IRS MIN.	Month, Day, Year)	8. 1	Sout	E (State or Foreign h Carolin
TOR	Deaton Nursing Ho	ome-601 S. Charle	es St	Balti	more			n/a	
DIRECTOR	10b. COUNTY		10c. CITY, TOWN			·			INSIDE CITY LIMITS?
	Maryland n/	a	Ba	altimor			10g. CITIZEN	75	YES 2 NO
FUNERAL	46 North Wheeler	Ave		101. 219	21223			JSA	SOUNTHY
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES	MED 13	If yes, specify		ORIGIN? (Specify Yer Puerto Rican, etc.)	or No 14.	RACE - A Black, Whi Specify:	merican Indian, te, atc.
	15. DECEDENT'S EDUC (Specify only highest grade	completed) (Gi	CEDENT'S USUAL (e during most of t	working	16b. KIND OF BUS	SINESS/INDUST	TRY	Diagram
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Do NOT use retired.)		_			
MP	11th Grade 17. FATHER'S NAME (First, Middle, Last)	FO	restery			(First, Middle, Maiden	Baltimo	ore C	lty
	Brodie Lyde, Sr.			"		B. Hall	Sumerney		
BE	19a. INFORMANT'S NAME (Type/Print)	191	b. MAILING ADDRES	SS (Street and Ne		te Number, City or Tow	n, State, Zip Coo	de) 2	1223
5	Naomi Lyde	4	6 North	Wheele	r Avenu	e Balti	more,	_	
	20e METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remo	20b. PLACE /	AND DATE OF DISPO				CATION - City		
	4 Donation 5 Other (Specify)		metory or other place utus Me	moria	1 Park	20 Bal	Ltimore	Cou	nty, MD
	MOSLE!	M. Smet		2501 Gw Baltimo	ynns Fa re, Mar		Funera Vay 1216	ıl Hoı	mes, Inc.
	23. PART I. Enter the diseases, or o shock, or heart failure.	complications that caused the de List only one cause on each line	ath. Do not ente					,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	Facial Squa	MAIS	Carcin	0046				Onset and Death
	reaulting in daeth)	OUE TO (OR AS A CONSEC		0 0(11)	0,000				Jes
NO	Sequentially list conditions,	b. OUE TO (OR AS A CONSEC	OUENCE OF):						
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	e.							
H	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEC	OUENCE OF):						
ER	resoluting in death) Exst	d	-						
PHYSICIAN: MEDICAL C	PART II. Other algnificant condition	a contributing to death but not r	reaulting in the t	Underlying ca	use given in Pa	PERFO	RMED?	AWAII	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?
ME				/		_		1 🗆	YES 2 NO
AN:	DID TOBACCO USE CONTI		TH YES		JNCERTAIN				
ICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	ER:	De-14	C 00 041		-	
HYS	27. MANNED OF OEATH	26e. DATE OF INJURY	28b. TIME OF	28c. INJURY	Rasidence 6	ed. DESCRIBE HOW	INJURY OCCUR	RED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	1 YES	2 NO				
ED	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY — At he building, atc. (Specify)	ome, term, atreat, te	actory, office	2	est. LOCATION (Street City or Town, State		Rural Route	Number,
COMPLET	29a. CERTIFIER 1 DERTIFYING PHYSI	ICIAN: To the best of my knowledge, de	eath occurred at the	time data and	place and due to	the reuselet and me	nner se etete-f		
OMP	COST OTHY	R: On the best of axamination and/or						ause(a) and	manner as stated.
	296 SIGNATURE AND TITLE OF CERTIFIE	R		290	c. LICENSE NUMB	ER	29d. DATE S	IGNED (Mor	nth, Day, Year)
) BE	Mull	mo			D386	75	▶ 10	16/	95
10	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEATH (ITE	M 27) (Type Print)						

MA

21230

BAUTIMORE

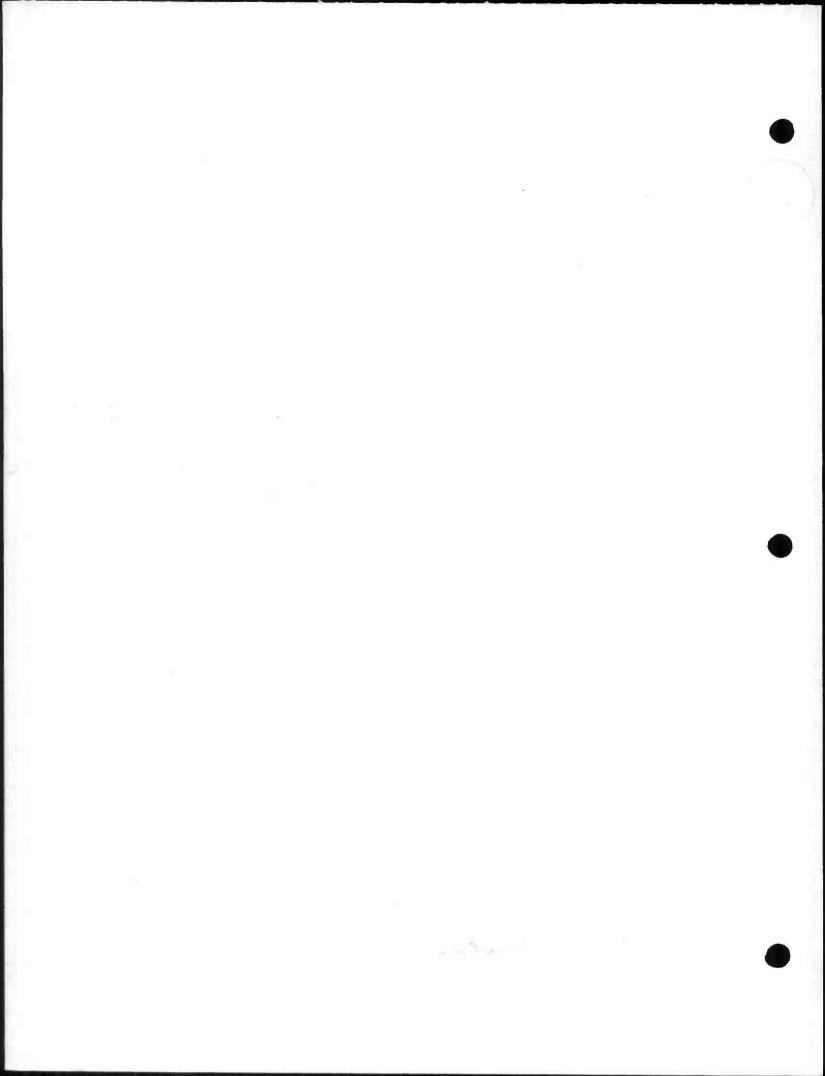
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

51

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31. DATE FLUED (Month, Day, Year)
067 1 9 1995

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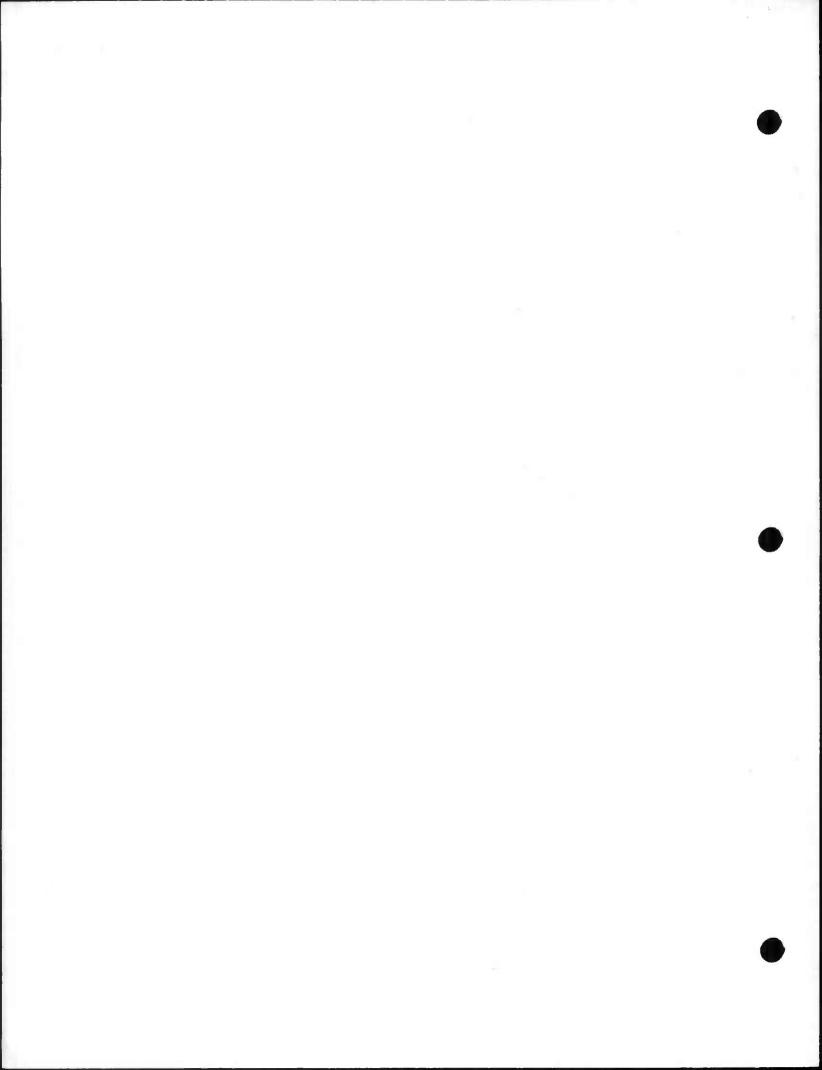


		FOR
1	-	STATE
		REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTI	FICATE OF	DEATH	REG. N	0.		
1. DECEDENT'S NAME (First, Middle					2. DATE OF DEATH			3. TIME OF DEATH
Gertru	rde m	10/1			OCT 1	DAY 14	795	5:50 PM
4. SOCIAL SECURITY NUMBER		. AGE (In yrs. last birthday	F UNDER 1 YEAR	IF UNDER 24 HRS,	7. DATE OF BIRTH		6. BIRTH	IPLACE (State or Foreign
155-14-4452	1 - M 27 NF	83 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Sept. 14	1 10	Counti	n/)
9e. FACILITY NAME (If not institution	, give street and number)		9b. CITY, TOWN	OR LOCATION OF DE			INTY OF D	
Charlestown RESIDENCE OF DECEDER 100. STATE Maryland E	Charlestown Nursing Center Catonsville Baltimo							
10e. STATE 10b. C	COUNTY	10c. C	TY, TOWN OR LOCA	ITION				10d. INSIDE CITY
Maryland E	Baltimore		Catons	ville				LIMITS?
				H. ZIP CODE		10g, CI	IZEN OF Y	WHAT COUNTRY?
To. STREET AND NUMBER 715 Maiden C 11. MARITAL STATUS 1 November Married 2 Married				21228	<u>. </u>	Un	ited	States
₹ \$\times \time	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 NO	If yes, s	CENDENT OF HISPAN pecify Cuben, Mexican 3 2 1 NO Specify		ee or No	Speci	
15. OECEDENT		16e. DECEDENT	S USUAL OCCUPATI	ON	16b, KIND OF B	USINESS/IN		ite
Elementary/Recordery (0.12)	College (1-4 or 5+)	(Give kind o	work done during m	ost of working	1.000.000	000000000000000000000000000000000000000	0001111	
d 9	Conege (1-4 or 5 +)	offi	ce mana	ger	jewe	elrv		
9 17. FATHER'S NAME (First, Middle, Le	ist)				ME (First, Middle, Maide			
Mathias Gnei	ting			1	e Durr	ii Surieme)		
M 100 INFORMANT'S NAME (Too Die		10h MAN IN	O ADDRESS (Street		Coute Number, City or To		-	
0								21227
Elsie Witti					et Lanso			
20a METHOD OF DISPOSITION 1 Burial 2 Cremetion 3	Removal from State	20b, PLACE AND DATE cemetery, crematory or	other place)			OCATION —		
4 Donation 5 Other (Specify 21. SIGNATURE OF FUNERAL SERV		Lakevie		ial ND ADDRESS OF FAC	10/20 Sy	kest	7111	e,Marylan
1000	TOE CIOENS)0			eral Hon	ne of	T _a	nsdowne
Selson	1	et.	2719	Hammon	ds Ferry	ROS	h d	21227
23. BART I. Enter the disease	s, or complications that c	eused the deeth. Do	not enter the me	ode of dying, such	as cardiac or rea	piratory ar	Teat,	Approximata
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. OV	TO BELLY TO RAS A CONSEGUENCE	e Heo	yt fo	rilure			Interval Between Onset and Daath
	DUE TO (OI	C Sten	OF):		W			14.
O Sequentially list conditions,				1,400/	Rague	1		740
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSEQUENCE	OF):					
CAUSE (Disease or Injury	c	R AS A CONSEQUENCE						
that initiated events resulting in death) LAST	502 10 (0)	A AS A CONSEQUENCE	OF):					
	d							
	ditiona contributing to de	eth but not reculting	In the underlyin	g cause given in i	Part I. 24s. WAS A	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
PART II. Other algolificent con					PERFO	RMED?		AMILABLE PRIOR TO COMPLETION OF CAUSE
DJ III					1 □ YES	2 No		OF DEATH?
DID TORACCO LISE CO	ONITRIBLITE TO CALL	CE OF DEATH V	TC T NO E	72 110 10007410				1 - YES 2 - 10
DID TOBACCO USE CO			ATH (Check only one)		<u> </u>			
EXAMINER?	HOSPITAL:	28. PLACE OF DE	OTHER:					
(f) 1 □ YES 2 2000		R/Outpatient 3 DOA		ne 5 🗆 Reeldence	6 Other (Specify)			
27. MANNER OF DEATH	26e. DATE OF IN. (Month, Day,	JURY 26b. Til		JURY AT DRK?	28d. DEŞCRIBE HOW	INJURY OC	CURED	
Accident Investig	ation			YES 2 NO				
3 Suicide 6 Could n	building, etc	NJURY — At home, lerm, (Specify)	street, factory, offic	:0	281. LOCATION (Street City or Town, Stets		or Rural A	loute Number,
290. CERTIFIER								
(Check only one)	PHYSICIAN: To the best of my							
299. CERTIFIER 1 CERTIFYING (Check only one) 2 MEDICAL EX	AMINER: On the basis of exam	nnation end/or investigat	ion, in my opinion, o	feath occured at the t	time, date end place, e	nd due to I	te cause(s) end menner es stated.
296. SIGNATURE AND TITLE OF CEI	TIFIER			29c. LICENSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
30, NAME AND ADDRESS OF PERSO				1340	1-3	10	7	17,1995
30. NAME AND ADDRESS OF PERSO	ON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Typ	e, Print)		,			
09-7 Ans	leboum,	m/J	711 m	aidin	Chois	-	Lon	e21228
"OCTI"91995"	ALL OTHER	A THE						

BALTIMORE, MARYLAND 21215-0020



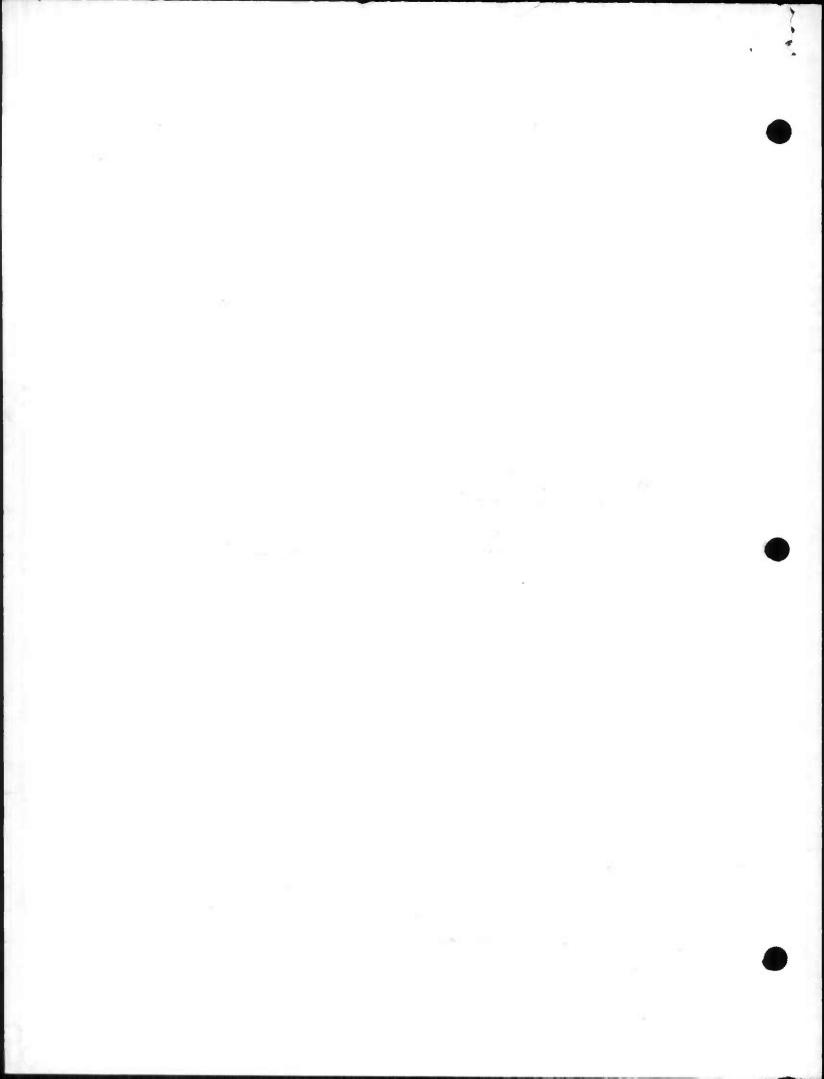
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE							
	REGISTRAR CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 1. 3. "	11.38 p M						
		CE (State or Forbign						
TOR	98/ FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH PRESIDENCE OF DECEMENT 98. COUNTY OF DEATH 96. COUNTY OF DEATH 97. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 97. CITY, TOWN OR LOCATION OF DEATH 98. COUNTY OF DEATH							
DIRECTOR		I. IHSIDE CITY LIMITS? YES 2 NO						
FUNERAL	3925 Grantley Rd 101. ZIP CODE 10g. CITIZEN OF WHAT	COUNTRY?						
BY FUN	THE PARTY OF THE P	American Indien, hita, etc.						
ED	15. DECEDENT'S EDUCATIOH (Specify only highest grade completed) (Give kind of work done during most of working							
COMPLET	Elementary(Secondary (0-12) College (1-4 or 5+) NOT use refired. Single Superior Single							
TO BE		1 2						
F	O TOTAL CHINISTIAN TOO SUNSE! KINGE IS 130 HO	nd 21133						
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20s. PLACE AND DATE OF DISPOSITION (Name of Cartier), carefully of Town, ca	own, Ad						
	21. BIGHATURE OF TUNIFIAL SERVICE LICENSES							
	1300 wabash Denye Bal	tond						
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line.	Approximats Interval Batween						
	IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	Onset and Death						
	DUE TO (OR AS A CONSEQUENCE OF):							
NOI	Sequentially list conditions, a Atherocal evotic Camboracular Wigere							
CAT	If any, (sading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury							
RTIFICATION	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST							
CE								
		FRE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE						
		AILABLE PRIOR TO						
		AILABLE PRIOR TO MPLETION OF CAUSE DEATH?						
		AILABLE PRIOR TO MPLETION OF CAUSE DEATH?						
		AILABLE PRIOR TO MPLETION OF CAUSE DEATH?						
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Control Cont	AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO						
ED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. A	AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO						
ED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. A	AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO						
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	AILABLE PRIOR TO MMPLETION OF CAUSE DEATH? YES 2 NO Number, Number,						
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO 1 VES 2 NO NO NO NO NO NO NO	AILABLE PRIOR TO MMPLETION OF CAUSE DEATH? YES 2 NO Number, Number,						
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	AILABLE PRIOR TO MMPLETION OF CAUSE DEATH? YES 2 NO Number, Number,						



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

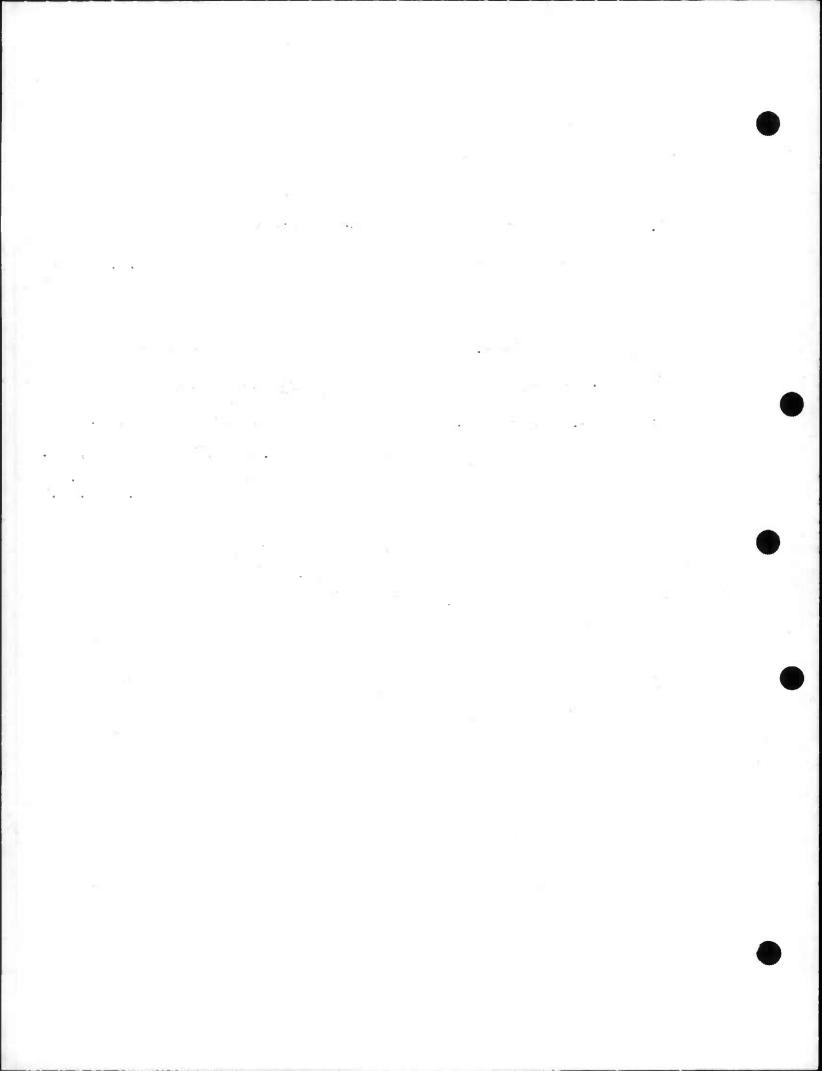
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
ITTENDING PHYSICIAN: The law requires that the death certificate be executed within Ta	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral d within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR	TO THE FUNERAL DIRECTOR: After this come filed within 72 hours after death with 1	IMPORTANT: If Item 28 is marked

RAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH	ND MENTAL HYGIENE REG. NO.	
NAME (First, M	fiddle, Last)	2. DATE OF DEATH MONTH DAY	YEAR
n l	Madden	October 16 19	95

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF H	EALTH AND				
1. DECEDENT'S NAME (First, Middle, Last)		02111110	ALL OI	DEATH	2. DATE OF DEATH			3. TIME OF DEATH
	n							2:35 A M
218-18-2432	1 M 2 □ F 6	100		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		Country	PLACE (State or Foreign
FORT HOWARD VE					DEATH	9c. COUNT	Y OF DE	ЕАТН
10e. STATE 10b. COUNT								10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER		1	101.	ZIP CODE		10g. CITIZE	N OF W	YES 2 NO
717 DRUID PAR	RK LAKE DRI	VE		21217				
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, spe	cify Cuben, Maxic	en, Puerto Ricen, etc.)	or No-	Black,	— American Indian, White, etc. V: ACK
15. DECEOENT'S EDU	ICATION	16a. DECEDENT'S USE	JAL OCCUPATIO	N	16b. KIND OF BU	SINESS/INDUS		HOK
Elementary/Secondary (0-12) N/A	College (1-4 or 5+)	IIIe. Do NOT use re	tired.)	t or working	RACE I	RACK	CUI	RCIUT
17. FATHER'S NAME (First, MIGGIE, Last) AVON MADDEN	J			HOR'	TENSE JOH	INSON		
192. INFORMANT'S NAME (Type/Print) MRS. JEAN MANN	NS .	196. MAILING AD 5330 I	ORESS (Street of IBERT	M HEIG	Route Number, City or Tow HTS AVE.	BALT	ro.	,MD. 21207
20a_METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	BA	PLACE AND DATE OF D	ISPOSITION (Nar	NAL CE	O/95E 20c. LO METERY BA	CATION — CR	y or Tow	, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE DEWIS T	. GWYNN				PAT. F	IOM	E 21215
Lewis.	I Sevyn	14.)						LTO.,MD.
IMMEDIATE CAUSE (Finel disease or condition	List only one couse on e	sch line.				ratory srres	et,	Approximate Interval Between Onset and Death
				MC 640 CG				5/95
If any, leading to immediate cause. Enter UNDERLYING								5/95
that initiated events resulting in deeth) LAST								Unknown
PART II. Other algolificant condition	as contributing to death b	ut not resulting in ti	ne underlying	cause alven in	Part I at uno au	ALFROMOV		
Cachexia		or not resolving in the	ne dilderiying	causa given in	PERFOR	IMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTI	PIRLITE TO CAUSE O	E DEATH VEC	Z NO \square	LINICEDTAL				1 D YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				UNCERIAI	NU	0		
EXAMINER? 1 ☐ YES 2 💢 NO	HOSPITAL: 1 XInpatiant 2 - ER/Outp			5 Residence	6 Other (Specify)			
27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)		28c. INJU WOR	RY AT		NJURY OCCUP	PEO	
3 Suicida 8 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY building, etc. (Spec	At home, farm, strae	t, factory, offica		28f. LOCATION (Street a City or Town, State)	and Number or	Rural Ro	ute Number,
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowl	edge, death occurred at	the time, data a	and place, and due	to the cause(a) and mar	nner as stated.		
				29c. LICENSE NU	MBER		IGNED (Month, Day, Year)
30, NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF OE	ATH (ITEM 27) (Type. Prin	0	D 305	28	00	I	ben 1995
				ort How	ard, MD 2	1052		
OCT 1 9 1995	22. PROSTRAR'S SUPPLY	ATUSE				-		
	1. DECEDENT'S NAME (First, Middle, Last) Molvin Madde 4. SOCIAL SECURITY NUMBER 218-18-2432 9a. FACRLITY NAME (If not institution, give is FORT HOWARD VI FRESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND 10c. STREET AND NUMBER 717 DRUID PAF 11. MARNITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEOENT'S EDU (Specify) only highest gradue Elementary/Secondary (0-12) N/A 17. FATHER'S NAME (First, Middle, Last) AVON MADDEN 19a. INFORMANT'S NAME (Type/Print) MRS JEAN MANN 20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIK PURSO 23. PART I. Enter the disease, or of shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) 23. PART II. Other algnificant condition CAUSE (Disease or injury that initiated events resulting in death) PART II. Other algnificant condition Cachexia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicida 6 Could not be detarmined 29a. CERTIFIER (Check only one) 1 CERTIFIER 30. NAME AND AOORESS OF PERSON WHE Bala Duggirala,	1. DECEDENT'S NAME (First, Middle, Last) Me] Vin Madden 4. SOCIAL SECURITY NUMBER 5. SEX 218-18-2432 9a. FACILITY NAME (If not Institution, give atreet and number) FORT HOWARD VETERANS ' HO RESIDENCE OF DECEDENT 10b. STATE 10b. COUNTY MARYLAND 10c. STREET AND NUMBER 717 DRUID PARK LAKE DRI 11. MARITAL STATUS 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Separation 13. DECEDENT'S EDUCATION (Specily only highest practic composition) Elementary/Secondary (0-12) N/A 17. FATHER'S NAME (First, Middle, Last) AVON MADDEN 19a. INFORMANT'S NAME (PyporPrint) MRS . JEAN MANNS 20a. METHOD OF DISPOSITION 1 Sequentially liet conditions, or heart fellure. List only one celese on e shock, or heart fellure. List only one celese on e immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) DID TOBACCO USE CONTRIBUTE TO CAUSE OF EXAMENER: 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 5 Pending 1 Netured 6 Person Who Complete Cause of Mount, Day, New) 1 Netured 6 Person 1 Neture Characteristics 1 Netured 6 Person 1 Neture Characteristics 1 Netured 6 Pending 1 Netured 7 Pending 1 Netured 7 Pending 1 Netured 7 Pending 1 Netured 8 Pending 1 Netured 8 Could not be detarmined 2 Decedent 1 Neture Person	1. DECEDENT'S NAME (First, Middle, Last) Mel Vin Madden 4. SOCIAL SECURITY NUMBER 2. 18—18—2432 1 May 2 F 69 VRS. 30. FACILITY NAME (if not institution, give street and number) FORT HOWARD VETERANS' HOSPITAL TRESTDENCE OF DECEDENT May STATE 100. COUNTY MARYLAND 100. STREET AND NUMBER 7.17 DRUID PARK LAKE DRIVE 11. MARYLASTATUS 1 Never Married 2 Merried 3 Notword 4 Devorced 6 /8 / 45 - 11/24 / 46 11. MARYLASTATUS 1 Never Married 2 Merried 3 Notword of Disposition (Specify) Property 1 Nover Married 2 Merried 3 Notword of Disposition (Specify) Property 1 Nover Married 2 Merried 3 Notword of Disposition Semprephysical Conditions of Organics (Specify) Property 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Notword of Disposition 1 Nover Married 2 Nover Married 2 Notword of Disposition 1 Nover Married 1 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 3 Nover Married 4 Nover Married 5 Nover Married 5 Nover Married 5 Nover Married 5 Nover Married 5 Nover Married 6 Nover Married	1. DECEDENT'S NAME (First, Middle, Last) MCIVIN MCIDEN 1. SECEDENT'S NAME (First, Middle, Last) MCIVIN MCIDEN 1. SECURITY NUMBER 2. 18—18—2432 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 18 SEX 2. 18 M2 F 69 19 SEXTITY, TOWN OF LOATH MARYLAND 19 C. CITY, TOWN OF LOATH MARYLAND 10 C. STREET AND NUMBER 7. 17 DRUID PARK LAKE DRIVE 11. MARIFAL STATUB 12. WAS DECEDENT SUPEN N. U.S. ARMED 13 WIGHOWAY 14 News MARYLAND 15 SEX SEX 18 SEX 18 SEX 19 SEX 19 SEX SEX	1. STATE PROGRESS ANAME (First, Modes, Late) MICHAEL NAME (First, Modes, Late) MICHAEL NAME (First, Modes, Late) MICHAEL NAME (First, Modes, Late) MICHAEL NAME (First, Modes, Late) A. SOCIAL SECURITY NUMBER 2. SEX 3. SEX 2. SEX 2. SEX 2. SEX 2. SEX 2. SEX 2. SEX 2. SEX 2. SEX 3. SEX 2. SEX 2. SEX 2. SEX 3. SEX 2. SEX 2. SEX 2. SEX 3. SEX 2. SEX 2. SEX 3. SEX 2. SEX 2. SEX 3. SEX 2. SEX 3. SEX 2. SEX 3. SEX 2. SEX 3. SEX 2. SEX 3. SEX 2. SEX 3	1. DECEDENT BANKE (PM. MORE), Lately M. PERCHANDER OF DEATH 1. DECEDENT BANKE (PM. MORE), Lately M. PERCHANDER OF DEATH 1. DECEDENT BANKE (PM. MORE), Lately M. PERCHANDER OF DEATH 1. SECOLA SECURITY MARKER (PM. MORE) 2. SACK SECURITY MARKER (PM. MORE) 2. SACK SECURITY MARKER (PM. MORE) 2. SACK SECURITY MARKER (PM. MORE) 3. SACK SECURITY MARKER (PM. MORE) 3. SACK SECURITY MARKER (PM. MORE) 4. SOCKAL SECURITY MARKER (PM. MORE) 5. SACK SECURITY MARKER (PM. MORE) 5. SACK SECURITY MARKER (PM. MORE) 5. SATE MARKER STATUS 5. SATE MARKER STATUS 5. SATE MARKER STATUS 5. SATE MARKER STATUS 5. SACK SECURITY 5. SATE MARKER STATUS 5. SACK SECURITY	1. STATE OF BRATILARD / DEPART MENT OF HEADIN AND MENTAL HYGIENE REGISTROAD 1. DECEDENT 9 MARK (PRIX. ALGOS, LAU) MC LYTH MAGGIC 4. SOCAL SECURITY HAMBERS 5. SOCAL	1. STATE OF MARTINARY DEPTH HANDS AND MERNAL PYSICAL AND MARKET AND MERNAL PROJECTION OF DEATH MICHAEL MARKET MAR

				NO	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TIE	l iii	N C	20	ME	ż	A	SIC	×	d	m			PLE	M	ü	BE	0	
exan	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam	the	event,	natic	traur.	other	10 '	injury	amy	SW0	3 sh	n 2	Her	, 0	rked	E	- 00	n 2	Item	T: H	TAN	POR	E	
	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ation,	. crem	o burial	prior t	удівпе	E	d Mer	th an	f Heal	pt. o	6	State	the state	with	death	ter	Sal	Pon	n 72	with	Fled	8	
fune	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune	ly filled	mplete	and co	ysician	fing ph	ttend	the a	ed by	n Sign	Dee	has	ficate	Certi	this	After	98	5	DIR.	ERAL	F	出	2	
deat	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	F	d within	execute	nte be	certifica	ath	the de	that	quires	W re	96	E.N	SICLE	PHY	JING	ENC	A	8	PITA	55	뿔	2	

	1 - FOR STATE REGISTRAR	STATE OF MAR			MENT OF			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) MCCLOUD	EVIE						2. DATE OF DEATH	7 19	YEAR	3. TIME OF DEATH 2.43 am M
	4. SOCIAL SECURITY NUMBER 243-56-1707	1 □ M 2 🛣 F	GE (In yrs. les		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-19-3	7	Country	Sissippi
TOR	90. FACILITY NAME (If not institution, give s Northwest Hosp RESIDENCE OF DECEDENT		cer	}	96. CITY, TOWN	or LOCATIO				time	
DIRECTOR	10a. STATE 10b. COUNT	imore		10c. CITY,	TOWN OR LOC	ation dalls	stow	m			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	4121 Tiverton	Road				2113			1111	ZEN OF W	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 1 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O	ES 2 3		If yes,	CENDENT Opecify Cube	n, Mexica	IIC ORIGIN? (Specify Yer n, Puerto Ricen, atc.)	or No	14. RACE Black, Specifi	- American Indian, White, atc. Black
APLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(G	CEDENT'S University Months of Months	ork done during in retired.)	TION nost of workin	g	Educ			
E COMPL	17. FATHER'S NAME (First, Middle, Last) James S. Morr	is						ME (First, Middle, Meiden			
TO BE	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stree			Poute Number, City or Tow		Code)	
-	Charles J. Mo	Cloud Sr					Road	l Randall			
	20s. METHOD OF DISPOSITION 1 Burlel /2 Cremation 3 Rem 4 One Other (Specify)	oval from State	cemetery, cre	MAND DATEO	F DISPOSITION (ieme of	- -	10/19 OW	CATION —	City or Tow	n, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE /	Gari	ISON		AND ADDRES					
Ц	Munerflez	Redd						al Servic	e St	.Ba	7 N.Monro
CERTIFICATION	23. ART I. Enter the diseases, or shock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. He fa	to the transfer of the transfe	FOU DUENCE OF	line, hyp	Secon	do	on re	fra	y far	Approximate interval Between Onset and Death
MEDICAL C	PART II. Other significent condition	e contributing to deep	h but not r	esulting in	the underlyi	ng cauee g	iven in	Part I. 24a. WAS AN PERFOR	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEA	TH YES	□ NO I	JUNC	ERTAIN	V D			1 ☐ YES 2 Ø NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			Check only on)					
HYS	1 YES 2 NO	1 Inpatient 2 ER/0		DOA 28b. TIME		me 5 Re	sidence	6 Other (Specify) 28d. DESCRIBE HOW I	N III I I O O O	HIBEO	
ВУ Р	1 Natural 5 Pending	(Month, Day, Ye	er)	INJU	RY V	ORK7 YES 2 _] NO	200. DESCRIBE NOW)	NJUHT OCC	UNEU	
0	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJ building, atc. (URY — At ho Specify)	me, ferm, sti	reel, fectory, of	ce		261. LOCATION (Street a City or Town, Stete)	and Number	or Rural Ro	oute Number,
COMPLET		CIAN: To the best of my ki									end manner ea stated.
BE C	295 SIGNATURE AND TITLE OF CERTIFIER	0				29c. LICE	NSE NUM	IBER	29d. DATE	E SIGNED	Month, Day, Year)
TO E	30. NAME AND ADDRESS OF PENSON WH	vere /Sa	321	· un	v)	1)3	145	0,	00	tob	et7, 1995
	ASHWAMI K. B	ASST /			rint) T 11US	PURT	- (1	EMIEL			
	31. OCT 1 9 1995	32 REGISTRAR'S S	IGNATURE				1				91/23

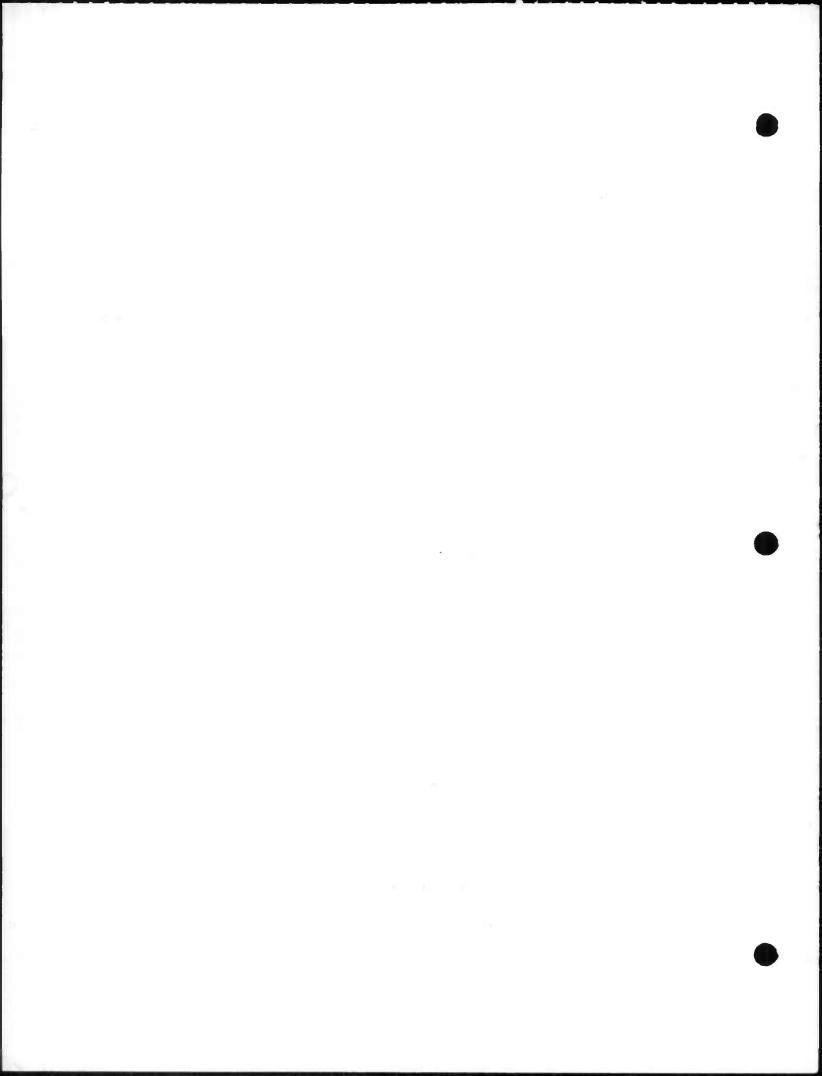


MORE, MARYLAND 21215-0020

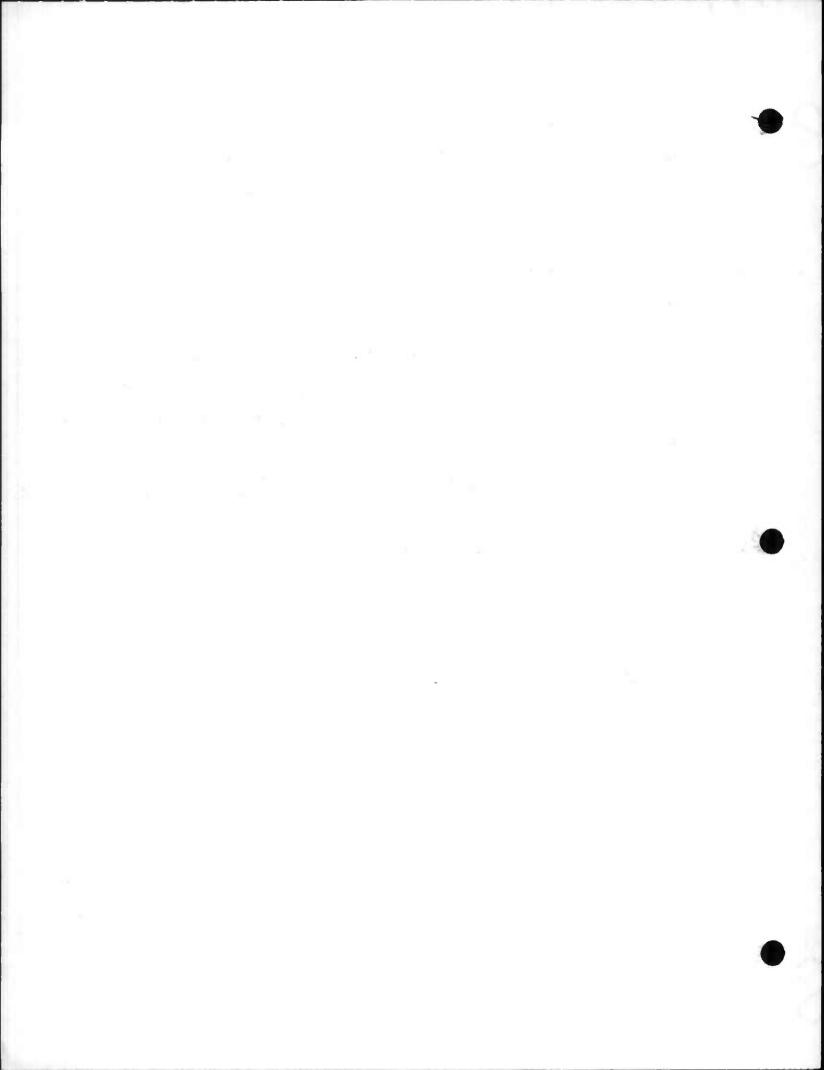
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OCCUTAL DO ATTENDIAL DUVELORAL The last requires that the death confidence he manufact within 24 hours about Da
<u>N</u>	S OINING
2	ATTE
\leq	90
	OCBITAL

O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITA.	TO THE FUNERAL	be filed within 72	IMPORTANT: 11

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTMI			MENTAL HYG						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	'N		TIME OF DEATN			
	Buster McEa	chern				10/1	3795	YEAR	4:00PM m			
			in yrs. last birthday) IF U	NDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1 1	B. BIRTHPL/	ACE (State or Foreign			
	237-26-1680 1. 9a. FACILITY NAME (If not institution, give street	M 2 D F 75	YRS. MONT	ST TONII	HOURS MIN.		/13.2 0	SOUTH	CAROLINA			
DIRECTOR	Seton Hill Man				Balto		1201	N/A				
Ä	10a. STATE 10b. COUNTY	-	10c. CITY, TO	WN OR LOCA	ION			10	d. INSIDE CITY LIMITS?			
	MARYLAND N/A	ł.		BALTIM	ORE CITY			11	Y YES 2 NO			
FUNERAL	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZE	EN OF WHA	T COUNTRY?			
<u> </u>	717 DRUID PARK LAKE	DRIVE			21217		τ	JSA.				
5		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF NISPAN	HC ORIGIN? (Specif	y Yes or No- 1		American Indian, hita, atc.			
ВУБ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Specifi	n, Puerto Rican, etc y:)	Specity:	nna, aic.			
							l <u>I</u>	BLACK				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	iON npleted)	(Give kind of work of	lone during mo	ON st of working	16b, KIND OF	BUSINESS/INDU	STRY				
<u> </u>	Elementary/Secondary (0-12) UNKNOWN	College (1-4 or 5 +)	ille. Do NOT use retir			Dipp	TD CHOD					
₹			BARBER			BARB	ER SHOP					
8	17. FATHER'S NAME (First, Middle, Last)	M - E A CHIEDN				ME (First, Middle, Ma	,					
BE		McEACHERN			ESADO!	RA	l	BATHY				
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street a	nd Number or Rural	Route Number, City o	r Town, State, Zip C	Code)				
-	SANDRA LEE		3308 TR	ELLIS	LANE, A	BINGDON,	MD. 210	09				
	20s. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Remove	trom State	PLACE AND DATE OF DIS	POSITION (Na	me of	DATE 200	c. LOCATION — CI	ity or Town,	Stota			
	4 □ Donation 5 ☑ Other (Specify)	KI	NG MEMORIA	L PAR	CEMETE:	RY10-17-	95 WOODI	LAWN,	MARYLAND			
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME AL	D ADDRESS OF FA	CILITY						
	► (W	1) (5	m	1913	PH H. BRO	JWN JR.	FUNERAL RATTI	HOME	P.A. MD.21223			
7	23. PART I. Enter the diseases, or com- ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	COLD A	CONSEQUENCE OF)	NC	ER	ne cardiac of F	eaphatory arre-	at,	Approximate Interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL	PART II. Other algolificant conditions c	ontributing to death bu	ut not resulting in the	e underlyin	cause given in	PEI	S AN AUTOPSY REFORMED?	AM CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?			
Σ	DID TORACCO LICE CONTROL			7 110 6	·			1 (YES 2 NO			
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL				UNCERTAII	<u>ч </u>						
ᅙ	EXAMINER?	OSPITAL:		HER:								
<u>≥</u>	1 YES 2 NAO 1	Inpatient 2 ER/Outpe				8 Other (Specify)						
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	WC	28c. INJURY AT 28d. DESCRIBE NOW INJURY OC WORK?							
B	2 Accident Investigation	20 - 21 - 22 - 22 - 11 - 11 - 11			YES 2 NO							
TED	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Speci	— At home, term, street,	tactory, offic		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C	N: To the beat of my knowled On the basis of examination							d menner as stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER				29c LICENSE NUI	ABER	29d, DATE	SIGNED (M	onth, Day, Year)			
BE	Mushin	~	hu		Diar	71	► /2	1.11	CON			
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type Print)				16	7/10	177			
	RIKRISHWAN.	MD 82	1 N.EU.	7AW	57#	305	BAL	in	021-21201			
	OCT 1 9 1995 July	32 REGISTRAR'S SIGNA	64						1			



		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		f. DECEMBENT'S NAME (First, Middle, Land) A DATE OF DEATH ON SE DAY S. 1964 3.79 P. DAY ON SE DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY S. 1964 3.79 P. DAY ON SE DAY									
10		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 97 YRS. 6. AGE (In yrs. last birthday) 1									
3 should	æ	9e. FACILITY NAME (If not institution, give street end number) 9e. CITY, TOWN OR LOCATION OF DEATH 9e. COUNTY OF DEATH									
1, 2,	CTOR	St. ELIZA BETH NURSING CENTER BALTO. CITY WA									
. Pages	DIRE	100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION BALTO CITY 104. INSIDE CITY LIMITS? 1 - YES 2 NO									
permit		10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?									
DZO physician, burial-transit	FUNERAL	3320 BENSON AVE "2/229 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian.									
	ВУ	1 Never Married 2 Married 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO Specify: Spe									
w atte	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the December 2014) 16b. KIND OF BUSINESS/INDUSTRY									
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	COMPLE	8 College (1-4 or 5+) ###. De NOT Use refered.) ### De NOT Use refered.) ### De NOT Use refered.) ### OWN HOME									
S & E		17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surneme)									
retained by 5 should by notified a	TO BE	ANTHONY JANNEO ROSE LIBERTINI 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21053									
y be rage 5	F	EVELYN ENGLE 1909 BILL SAWMILL RD. FREELAND MD.									
E e e		20b. PLACE AND DATE OF DISPOSITION 1 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of certainly prematory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State									
ALLIMOT death. Page 6 m funeral director, i. examiner mus		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY									
2 - 2 - 0		23 PART I From the disease or complications that event the destination of the first the disease or complications that event the first the disease or complications that event the destination of the first the disease of the destination of the first the disease of the destination o									
24 hours filled in t on, or re		ahock, or heart failure. List only one ceuse on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a									
B 2 2 2	_	DUE TO (OR AS A CONSEQUENCE OF):									
4 8 " O F	RTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
ficat phy ne p	FIC	CAUSE (Disease or injury the initiated events DUE TO (OR AS A CONSEQUENCE OF):									
th chi	CERT	resulting in death) LAST									
by the	CAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? AMALABLE PRIOR TO									
) = B = 8		arteriosclaratic coronary disesse Al aressian									
taw requires has been sign Dept. of Healt	N: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
# # # E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1									
PHYSICIAN: The this certificate with the State riked, or Item	PHY	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Dex Year) 280. TIME OF 280. INJURY AT WORK? 280. DESCRIBE HOW INJURY OCCURED									
	ВУ	1 Natural 5 Pending M 1 YES 2 NO									
28 after	ETED	3 Suicide s Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Yown, State)									
TAL OR A VAL DIRECT 72 hours If Item	COMPLE	29e. CERTIFIER (Check only one) One) APPROX. SYMMER B. To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated.									
TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 NO IMPORTANT: If IN	E CO	2 MEDICAL EXAMINER: Do the beele of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) end menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Care Vest)									
THE PO	0 BE	Jahrena Klallager Mrs 501786 >10-16-95									
>	-	20. NAME AND ADDRESS OF PERSON WID COMPLETED GAUSE OF DEATH (ITEM 27) (Typo, Print) L. GALLAGER, M.D. 3455 WILKENS AVE, BALTO, M.D. Z1229									
		31. DAY CT 1019 1995 July 22. FEGIS PAR'S SINATURE									

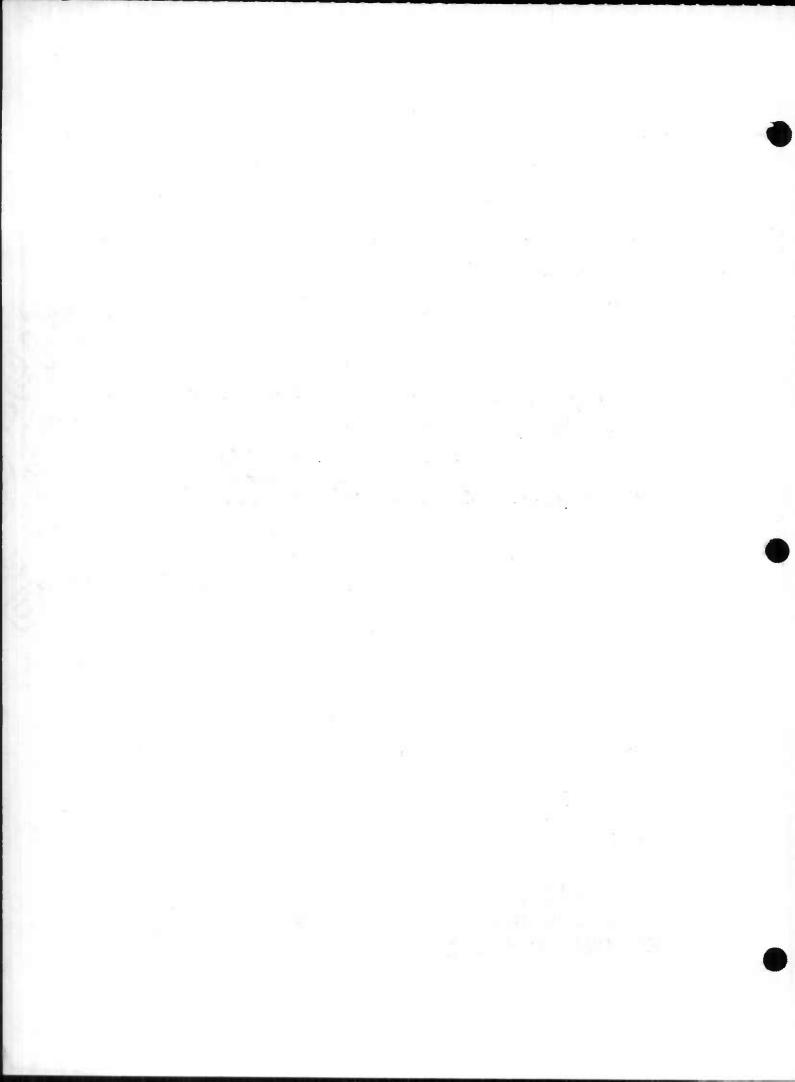


68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	bunal, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traum:

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR
	1. DECEDENT'S NA
	HEN
1	4. SOCIAL SECURIT
	22064
	9a. FACILITY NAME
	MERCY PRESIDENCE
	10a, STATE
	MD.
	100. STREET AND N
	11. MARITAL STATU
	1 Never Married
	3 Wildowed 4

	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DE	ATH	YEAR	3. TIME OF DEATH		
	HENRY OXENDINE				October	16 1	995	5:15p "		
	4. SOCIAL SECURITY NUMBER 6. SEX 6. AGE (In yrs. le		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day,	ITH Year)	6. BIRTHE	PLACE (State or Foreign		
	220645839 IRM20F 40	YRS.	- Carlo	NOONS WIN.	FEB 9	,1955	MA	RYLAND		
_	Sa. FACILITY NAME (If not institution, give street and number)	96	CITY, TOWN	OR LOCATION OF DE	EATH	. 0.00	DUNTY OF DE			
6	MERCY MEDICAL CENTER RESIDENCE OF DECEDENT	19	BALTI	MORE	MID	B	ALT. C	174		
DIRECTOR	10e, STATE 10b, COUNTY	10c. CITY, To	OWN OR LOCA	ATION				10d. INSIDE CITY		
E	MD. NA	B	AUTIN	DORE C	TV		1	LIMITS?		
	100. STREET AND NUMBER			DI. ZIP CODE	-	10g. (TIZEN OF W	HAT COUNTRY?		
ERAL	3313 RUCKERT A)e		2/2	14		US	A		
FUN I	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S., AI FORCES? 1 YES 2	RMED		CENDENT OF HISPAN			- 14. RACE	- American Indian, White, etc.		
BY F	1 Never Married 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced	NO		S 2 NO Specify		ore.)	Specifi	·		
- 61								er. INDim		
	(Specify only highest grade completed) ((ECEDENT'S USI Give kind of work e. Do NOT use re	done during n		16b. KIND	OF BUSINESS	INDUSTRY			
	Elementary/Secondary (0-12) College (1-4 or 5+)	LABO			0	INTO	UCT	Noi		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	LAUC	RER	18. MOTHER'S NA	ME (First Mirtella	Maiden Surnam	001	10.0		
	HENRY OXENDIA	15		SA	DIF	SAI	nDS	'on		
B			DRESS (Street	and Number or Rural	Route Number, City	y or Town, State,	Zin Codel			
유	DENISE OXENDINE 3	33/3	3 RI	scker	Ade	BA	702	1214 MD.		
		ANDDATEOF		Nama of	DATE	200 LOCATION				
	1 Suriel 2 Cremation 3 Department of Donation 5 Other (Specify)	ematofy or other	15 Co	emeters	1919	Dar	To. C	CITY		
-1	21. SIGNATURE OF PUNERAL SERVICE LICENSEE		23, MAME	AND ADDRESS OF FA	CILITY	SONS	FUN	enal Hort		
	Matriel War	2-11	13	22 8 1	1-0-0	OTT	3.173	21202 MD.		
4	PART I. Enter the diplomes, or complications that caused the d	eeth, Do not	enter the m	lods of dying, auc	h aa cardlac o	r respiratory		Approximate		
	shock, or peart failure. List only one ceuse on each lin	e.						Interval Between Onset and Death		
- 1	IMMEDIATE CAUSE (Final disease or condition		o neci	1:003100	e			2 1100.00		
ı	disease or condition a. A CQULYED IM DUE TO (OR AS A CONSI	EQUENCE OF):	ODEFI	Clero	MADIN	PLC .		2 900		
z	things In	CAL MAN	DET	VIENL	Vizu	S		4 years		
CERTIFICATION	Sequentially list conditions, It any, landing to immediate by the sequence of									
3	CAUSE (Disease or injury									
	that initiated events DUE TO (OR AS A CONSI	EQUENCE OF):								
E	d			-						
	PART II. Other aignificant conditions contributing to deeth but not	resulting in 1	the underlyi	ng cause given in	Part I. 24e.	WAS AN AUTOP	SY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ICAL	Preumocystis Carinii Pr	enmo	nia			YES 2 T NO		COMPLETION OF CAUSE OF DEATH?		
NED I	Mycobacterium Arium Int			Infection		1	34.2	1 TYES 2 N NO		
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE						. 11 .::			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	CE OF DEATH		•)						
S	1 YES 2 NO 1 Inpatient 2 ER/Outpetient	3 DOA 4	THER:	ome 5 🗆 Residence	6 Other (Spe	cify)				
H	27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year)	26b. TIME C	Y V	HJURY AT VORK?	28d. DESCRIBI	E HOW INJURY	OCCURED			
BY	1 Netural 5 Pending 2 Accident Investigation			YES 2 NO						
ED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At 9 building, etc. (Specify)	noma, farm, atre	et, factory, of	fica	261. LOCATION City or Tow	(Street and Nur n, State)	nber or Rural R	loute Number,		
ET										
립	29a. CERTIFIER (Check only one)									
COMPLET	2 MEDICAL EXAMINER: On the basis of examination and/o	r investigation,	In my opinion	, death occured at the	time, data and p	place, and due	to the cause(s) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	11.11		29c. LICENSE NU				(Month, Day, Year)		
10 E	Shelly yours, UD			1709	134		October	16,1995		
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT				. 01					
	SHELLY JONES 40 MERLY MEDICA	AL CT	R 3	32 Bt. Pa	ul Pl	ale P	BITIM	ore, min		
	31. DATE FILED (Month, Day, Your) OCT 1 9 1995 July Drugler R. J.									
	and ammerial	4								



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

	1. DECEOENT'S NAME (First,	Middle, Last)								2. DATE OF DEATN		HELD	3. TIME OF DEATN
	ROBERT	WILL]	IAM PTAR	<						October 1	4,19	95 ^{EAR}	7:10 A. M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	. last birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH		S. BIRTI	NPLACE (State or Foreign
- 1	214 40 2127	7	1 🔀 M 2 🗆 F	53	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 04 01 42		Mar	vland
į	Se. FACILITY NAME (If not in.					oh CIT	V TOWN	OR LOCAT	ON OF DI		1 00 001	INTY OF C	-
- 1	359 Bonsa					90. GIT		ltimo		EATN			, LAIN
5	the second second second					1	Ba.	TCTIIO	re		IN	/A	
2	RESIDENCE OF DEC	10b. COUNTY	,		10c. CI	TY, TOWN	OR LOC	ATION					10d. INSIDE CITY
DIMECTOR	Md.		/A			Balt							LIMITS?
	10e. STREET AND NUMBER						1	IO1. ZIP COD	E		10g. CI1	IZEN OF	WHAT COUNTRY?
FUNERAL	359 Bonsa	al Stre	eet					21	224		U	SA	
5	11. MARITAL STATUS		12. WAS DECEDER	IT EVER IN U.S	ARMED	13.				NIC ORIGIN? (Specify Yes	or No-	14. RAC	E — American Indian, ik, White, etc.
	1 Never Married 2		FORCES?	MAR OR DATES	KINO			S 2 NO		n, Puerto Rican, etc.) y:		Spec	
à	3 Widowed 4 Divo	rced						A				Whi	te
E E		EDENT'S EDU		164	DECEDENT	S USUAL C	CCUPAT	TION nost of work		16b. KIND OF BU	SINESS/IN	DUSTRY	
ш	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT	use retired.)	during i	TRUST OF WORK	ny		c -		
COMPLET	12		3.57		Brick	Laye:	r			City o	i Ba	Itim	ore
5	17. FATHER'S NAME (First, M	liddle, Last)				- T		18, MO1	NER'S NA	AME (First, Middle, Maiden	Sumame)		
	Louis F	tak						M	arie	Schane			
RE	19a. INFORMANT'S NAME (7	lype/Print)			19b. MAILIN	G ADDRES	S (Stree	t and Numbe	or or Rural	Route Number, City or Tow	n, State, Z	ip Code)	
2	Patricia	A. Pta	ak		359	Bonsa	al S	Stree	t Ba	lto.,Md. 2	1224		
	20a. METNOO OF DISPOSIT			20b. PL/	ACE AND OATE						_	- City or T	own, State
	1 Buriel 2 Cremetic	(Specify)	oval from State	cemeter	y, crematory or	other place)		1	0-16-95	Balt	imore	e.Md.
	21. SIGNATURE OF FUNERA		CENSEE .	1 616	en Mo	22	NAME	AND ADDR	v				C)IM.
	100	0	n h.	00.						eiler & So			
	you	er &	J. Jeu	~~			5224	Eas	tern	Ave. Balte	O., M	d.	
	23. PART I. Enter the d		complications the List only one ce			not ente	r the n	node of dy	/Ing, suc	ch se cardisc or resp	Iratory a	rreat,	Approximate Interval Batwean
	IMMEDIATE CAUSE (FI		List only one ce	Donge	IIIIci.			11 1			11	٨	Onset and Death
disease or condition when were autoffe (meseum e)-													
- 1	resulting in death)	6.1	DUE TO	OR AS A CO	NSEQUENCE				(
,				Pas-	t- 6								
<u>5</u>	Sequentially list condit if any, leading to imme		DUE TO	OR AS A CO	NSEOUENCE	OF	7						
RTIFICATION	cause. Enter UNDERLY	ING		(a rot	and		and	un.	161 .			
Ĕ	CAUSE (Disease or Injuthat Initiated events	JIA J	DUE TO	OR AS A CO	NSEQUENCE	OF):		UV	/				
	resulting in death) LAS	ST T											
			d,										
- I	PART II. Other algoritics	ent condition	ns contributing to	death but	not resulting	in the u	inderly	ing ceuse	given in	Part I. 24a. WAS AP		/ 24	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
5	662	Sta								1 YES	A Company of the		COMPLETION OF CAUSE OF DEATN?
			-							/			1 TYES 2 TO
2	DID TOBACCO U	ISE CONT	RIBUTE TO CA	AUSE OF E	DEATH Y	res 🗆	NO	□ UN	CERTAI	N D			
PHYSICIAN:	25. WAS CASE REFERRED 1				PLACE OF DE								/
2	EXAMINER?		HOSPITAL:	□ ER/Outpatio	ot 3 lizaba	OTHE	R:	ome 5 do	mest.	8 Other (Specify)			
×	27. MANNER OF DEATN		26e. DATE O		26b. T			JURY AT	- Companie	26d. DESCRIBE NOW	INJURY O	CCURED	
	M	Pending	(Month,	Day, Year)		NJUPO	11	WORK?	□ NO				
B	2 Accident	Investigation	28a PLACE	OF INJURY —	Al borné foi	James Ho	1			281. LOCATION (Street	and Numb	or or Rum	Goute Number
	3 Suicide 6 4 Nomicide	Could not be determined		, etc. (Specify)	A Honge, talk	. actually to	ctory, or	iii.		City or Town, State)	Or I HAVE	TOOLS TOTALOS,
7	OTHER OTHER	TIFYING PNYS	SICIAN: To the best of	of my knowledg	ja, death occu	irred at the	time, d	ete and plac	e, and du	e to the cause(e) and me	inner ea si	leted.	
COMPLETED	one) /2 MED	DICAL EXAMINE	ER: On the baels of	examination en	id/or Investiga	tion, in my	opinion	, death occ	ured at the	e lime, data end placa, e	nd due to	the cause	(a) and manner sa stated.
	296. SIGNATURE AND TITLE	OF CERTIFIE	В					29c. LI	CENSE NU	IMBER	29d. D/	TE SIGNE	D/Month, Pay, Year)
B	/	7/4						/) 4	4260	•	101	18/95
2	30. NAME AND ADDRESS	F PERSON W	TO COMPLETED CA	USE OF DEATN	(ITEM 27) (Ty	pe, Print)		1	- (0	10	1	/
		10%	Z HAV	011	N.	D	cin-	1	12). Dr	40	mor	e my zizzy
	31. DATE FILED (Month Day	Xqu	32 REGIST	AR'S SENATE	IRE	V 0			, ,				7
	31. DATE FILED (Monty On	195	the diwel	or land	M								

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	2 1.11	CERTIFICAT	E OF DEATH	REG. NO.		3. TIME OF DEATH	
	James E.	Reenill	, Jr.		Zirct 1-	95		
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In y	.,	ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign	
	137-36-4871	1√2 M 2 □ F 4	9 YRS. MONTHS	DAYS HOURS MIN.	Jan. 31,		New Jersey	
~	9a. FACILITY NAME (If not institution, give :	street and number)	9b. CIT	Y, TOWN OR LOCATION OF D	EATH	9c. COUNTY		
DIRECTOR	NOTTH ATUND	el Hospith	6	len Burni	e	Anne	Arundel	
RE	10e. STATE 10b. COUNT	Y	10c. CITY, TOWN	OR LOCATION			10d. INSIDE CITY	
	Maryland An:	ne Arundel	Glen	Burnie			1 TES 2 NO	
FUNERAL				101. ZIP CODE	_		OF WHAT COUNTRY?	
N.	802 Paradise Lane	12. WAS DECEDENT EVER IN U.	e ARMED 13	2106 WAS DECENDENT OF HISPA			ed States	
	1 Never Married 2 Married	FORCES? 1 YES 2	2 NO	If yes, specify Cuban, Mexico	an, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc.	
BY	3 Widowed 4 Divorced	in the water tests of the control		1 YES 2 NO Specif	y.		Specify: White	
回	15. DECEDENT'S EDU (Specify only highest grade	CATION 16-	a. DECEDENT'S USUAL	during most of working	16b, KIND OF BUS	SINESS/INDUST	RY	
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retired.	,				
COMPL	17. FATHER'S NAME (First, Middle, Last)	2	Conducto		Rai1ro			
		1 0%			ME (First, Middle, Maiden	Surname)		
BE	James E. Reehil 19a. INFORMANT'S NAME (Type/Print)	l Sr.	196. MAILING ADDRES	Anna SS (Street and Number or Rural	Carroll Route Number, City or Town	State Zio God		
임	Mrs. Suzanne M.	Reehill		ise Lane Gle				
	20a. METHOD OF DISPOSITION	20b. PL.	ACE AND DATE OF DISPO	SITION (Name of		CATION — City		
	1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	Hol	ry, crematory or other place Y Cross Ce	metery Oct.				
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	22	. NAME AND ADDRESS OF FA	CILITY			
,	· Lou X	Chaugh		Kirkley-Rudd			ND 21061	
	23. PART I. Enter the diseases, or	complications that caused th	e death. Do not ente	21 Crain Hwy	. S.E. GLE:	n Burni	Approximate	
	ahock, or heart failure. iMMEDIATE CAUSE (Final	List only one ceuse on each	line.				interval Between Onset and Death	
Ì	disease or condition resulting in daeth)	. Given	v Ga				Zubs	
	Today or account	DUE TO (OR AS A CO	PHSEOUENCE OF):					
No.	Sequentially list conditions,	b	Warauruar an					
CATIO	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	INSECUENCE OF):					
의	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):			_		
RTIF	resulting in deeth) LAST	d.						
E	PART II Other elgoiticent condition	as contributing to death but a			I			
EDICAL	PART II. Other algnificant condition	e contributing to destri but i	not resulting in the u	inderlying cause given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
5 II					1 TYES 2	NO	OMPLETION OF CAUSE OF DEATH?	
W			DEATH VEC [7]				1 TES 2 NO	
Σ	DID TORACCO USE CONT	DIRLITE TO CALICE OF P		NO THEOTAI				
AN: M	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				N-EL]			
SICIAN: M		26.	PLACE OF DEATH (Check	k only one)				
SICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26, HOSPITAL: 1 inpetient 2 ER/Outpetie	PLACE OF DEATH (Check of 3 DOA 4 Nu 25b. TIME OF	R: Insing Home 5 Residence		JURY OCCURE	D	
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	26, HOSPITAL: 1 / inpetient 2 ER/Outpetie	PLACE OF DEATH (Check of 3 DOA 4 Nu	R: Irsing Home 5 - Residence	8 Other (Specify)	NJURY OCCURE	D	
D BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26, HOSPITAL: 1 inpetient 2 ER/Outpetie	PLACE OF DEATH (Check nt 3 DOA 4 Nu 25b. TIME OF INJURY	ronly one) ER: rising Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a			
ETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	26. HOSPITAL: 1 Joi Inpetient 2 ER/Outpetier 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY — J	PLACE OF DEATH (Check nt 3 DOA 4 Nu 25b. TIME OF INJURY	ronly one) ER: rising Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW II			
ETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check on) 1 CERTIFYING PHYSICAL	26. INDSPITAL: 1 Join Inpetient 2 ER/Outpetient 28. DATE OF INJURY (Month, Dey, Year) 28. PLACE OF INJURY — building, etc. (Specify)	PLACE OF DEATH (Check TO THE TO JOA 4 No. 25b. TIME OF INJURY M At home, farm, street, fact a, death occurred at the	x only one) IR: Irsing Home 5 ☐ Residence 28c, INJURY AT WORK? 1 ☐ YES 2 ☐ NO ctory, office	B Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	and Number or Re	ural Route Number,	
MPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check on) 1 CERTIFYING PHYSICAL	26. HOSPITAL: 1 Joinpetlent 2 ER/Outpetlet 26a. DATE OF INJURY (Month, Day, Year) 26b. PLACE OF INJURY — building, etc. (Specify)	PLACE OF DEATH (Check TO THE TO JOA 4 No. 25b. TIME OF INJURY M At home, farm, street, fact a, death occurred at the	x only one) IR: Irsing Home 5 ☐ Residence 28c, INJURY AT WORK? 1 ☐ YES 2 ☐ NO ctory, office	B Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	and Number or Re	ural Route Number,	
E COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26. HOSPITAL: 1 I Inpetiant 2 EN/Outpetie 28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY — building, stc. (Specify) ICIAN: To the best of my knowledg FR: On the besis of examination an	PLACE OF DEATH (Check TO THE TO JOA 4 No. 25b. TIME OF INJURY M At home, farm, street, fact a, death occurred at the	x only one) IR: Irsing Home 5 ☐ Residence 28c, INJURY AT WORK? 1 ☐ YES 2 ☐ NO ctory, office	B Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) end man time, date and place, and	nd Number or Ri mer as stated, d due to the cau	ural Route Number,	
BE COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check on one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	26. HOSPITAL: 1 Joinpetlent 2 ER/Outpetlet 26a. DATE OF INJURY (Month, Day, Year) 26b. PLACE OF INJURY — building, etc. (Specify) ICIAN: To the best of my knowledger. On the bests of examination and	PLACE OF DEATH (Check The street of the str	conly one) R: IR: Irshing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO Story, office time, deta and place, and due opinion, death occured at the	B Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) end man time, date and place, and	nd Number or Ri mer as stated, d due to the cau	ural Route Number,	
E COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26. HOSPITAL: 1 Joinpetlent 2 ER/Outpetlet 26a. DATE OF INJURY (Month, Day, Year) 26b. PLACE OF INJURY — building, etc. (Specify) ICIAN: To the best of my knowledger. On the bests of examination and	PLACE OF DEATH (Check THE STATE OF DEATH (Check THE STATE OF STA	conly one) R: IR: Irshing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO Story, office time, deta and place, and due opinion, death occured at the	B Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) end man time, date and place, and	nd Number or Ri mer as stated, d due to the cau	ural Route Number,	

permit. Pages 1, 2, 3 should

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DIRECTOR

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	TO THE HIGSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in a 24 hours after death. Page 6 may be retained by the hospital or attending physician
1	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra
_	be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.
	MEDOPTANT: If ham 28 is marked on liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

9

DRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6CA5164-

32. REGISTRAR'S SIGNATURE

Srontas.

OCT 1 9 1995

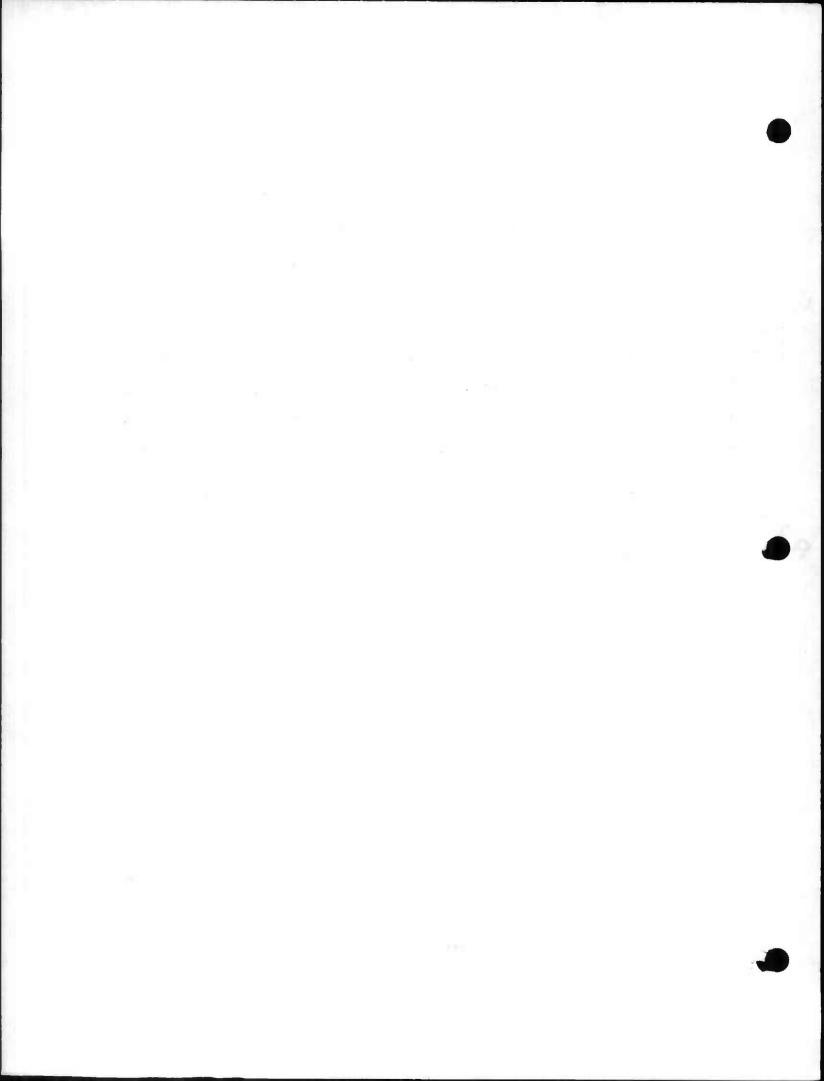
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCTOBER 16,1995 ALICE ROZENEL 11:30pm 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year DAYS MONTHS HOURS SEPT. 20,1916 GERMANY 1 M 2 F 216-30-7552 79 YRS. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4328 MARY RIDGE DRIVE RANDALLSTOWN BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND BALTIMORE RANDALLSTOWN 1X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4328 MARY RIDGE DRIVE 21133 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED t4. RACE — American Indian, Black, White, etc. FORCES? t YES 2 NO 1 Never Married 2 Married Specify 3 XWidowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) during most of working live kind of work done Do NOT use retired.) Elamentary/Secondary (0-12) College (1-4 or 5+) 12 OWNER/MANAGER BEAUTY SHOP 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MEYER MAILICH ROSA UNKNOWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number: City or Town, State, Zip Code) MR. SAMUEL ROZENEL 14 ADRIANNE COURT RANDALLSTOWN, MD 21133 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Surial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) BOBROISKER BENFICIAL CIRCLE LODGE 10-18-95-ROSEDALE, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE 21215 MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart feliure. List only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition_ 487ANATIC resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Max LIUGA Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) t TYES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | ODA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF 26c. INJURY AT WORK? 1 Natural 5 Pending Invastigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 8 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND WILE OF OFFIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Clasu D-20482 -

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ROLLYON (28W)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

214-14-8871 1 X M 2 D F 9a. FACILITY NAME (If not institution, give street and number) University of Maryland Sho	AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Pay, Yule)	8.	S 10:30 A BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Sho	73 YRS.	MONTHS DAY	S HOURS MIN.	(Month, Duy, mar)		Country)
University of Maryland Sho				5/4/22	1	Md
		9b. CITY, TOW	N OR LOCATION OF DE	ATH /	9c. COUNTY	Y OF DEATH
	ock Trama	Ba1	timore		N,	/A
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	I 40- 00	ry, town on Lo	CATION			10d, INSIDE CITY
						LIMITS?
Md Montgomery 10e. STREET AND NUMBER	3	ilver S	10f. ZIP CODE		10a CITIZE	N OF WHAT COUNTRY?
3330 N. Leasureworld Blvd 11. MARITAL STATUS 12. WAS DECEDENT	Apt 825 EVER IN U.S. ARMED	13. WAS	20906 DECENDENT OF HISPAN	C ORIGIN? (Specify Ye		JSA I. RACE — American Indian,
IF YES, OIVE WAS	YES 2 NO		, specify Cuban, Maxican YES 2 NO Specify:			Black, White, etc. Specify:
3 Widowed 4 Divorced			X			White
t5. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a, DECEDENT'S	work done during	ATION most of working	16b, KIND OF BL	SINESS/INDUS	STRY
Elementary/Secondary (0-12) College (1-4 or 5+)	ille. Do NOT L					
4+	Manag	er		1	inghous	3e
17. FATHER'S NAME (First, Middle, Last)			The second second	AE (First, Middle, Maider	Sumame)	
Arthur E. Roden			Leona V			
19a. INFORMANT'S NAME (Type/Print) Florence Roden			et and Number or Rural R			
	T					ing, Md 2090
20s. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State	20b. PLACE AND DATE cemetery, crematory or	other place!		1		ty or Town, State
4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Lake View		E AND ADDRESS OF FAC		cesvill	Le, Md
1 2 1			ling Ashto		Home	
Total Solh	120011		Edmondson			Md. 21228
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OR AS A CONSEQUENCE OF AS A CONSEQUENCE OF	1. GO	LF CAR	tion	20	CME I MON
CAUSE (Disease or Injury C.	OR AS A CONSEQUENCE (OF):	11 Mous	Jahren		
DARKE II Ohbar algoliticant and distance and	landa han and an airline	In the second of	"Ab		17.50	
PART II. Other algnificant conditions contributing to d	leath but not regulting	in the under	ying quust arten in	PERFO	N AUTOPSY PAMED?	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE
				1 - YES	2 × NO	OF DEATH?
DID TODACCO LICE CONTRIBUTE TO CAL	ICE OF DEATH V	TC TI NO	UNCERTAIN			1 TYES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAU 25, WAS CASE REFERRED TO MEDICAL	26. PLACE OF DE	ES NO		4 1 1		
EXAMINER? HOSPITAL:	ER/Outpatient 3 DOA	OTHER:				
27. MANNER OF DEATH 28e. DATE OF III			Home 5 Realdence	and Deposite How	INJUNY OCCU	PRED
1 Netural 5 Pending	25 12 8	UURY	WORK?	Sulmet	alle	on Galf Cart
2 Accidemt Investigation 3 Suicide 8 Could not be building a		11		INT. LOCATION (Stree	and Number of	Rural Boute Number And
4 Homicide detarmined building, e	Goff Cou	rsp		3330 N. L	edalla	world Blod
29a. CERTIFIER (Chack pake 1) CERTIFYING PHYSICIAN: To the best of n			date and place, and due			1.
(Check only one) 2 MEDICAL EXAMINER: On the basis of axe						
29b BIONAPUNE AND TITLE OF CERTIFIER			29c. LICENSE NUM			
John 1. Trillen				260	Þ /0	5/17/95
30. WAND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Total	oe, Print)			1	11/10
30. THE AND ADDRESS OF PERSON WHO COMPLETED CAUSE						
JOHN S. BRITTE	N					
JOHN S. BRITTE	'S SIGNATURE					

eriaje. Smith Histor

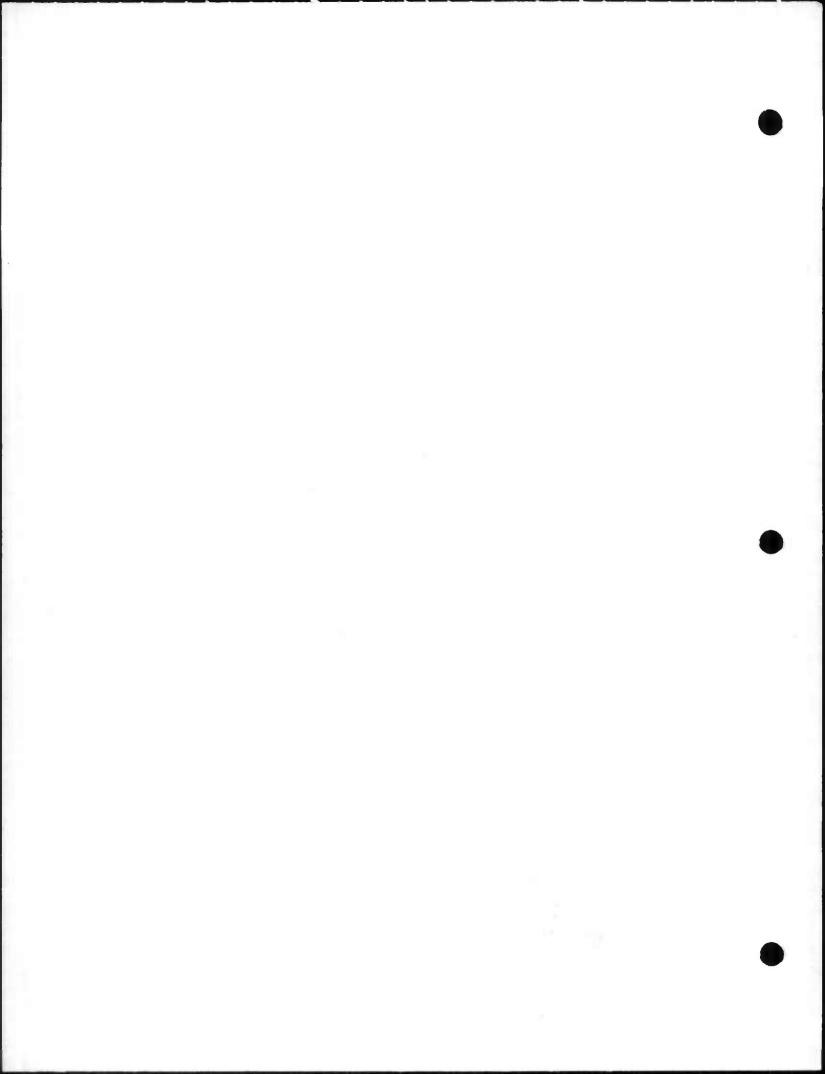
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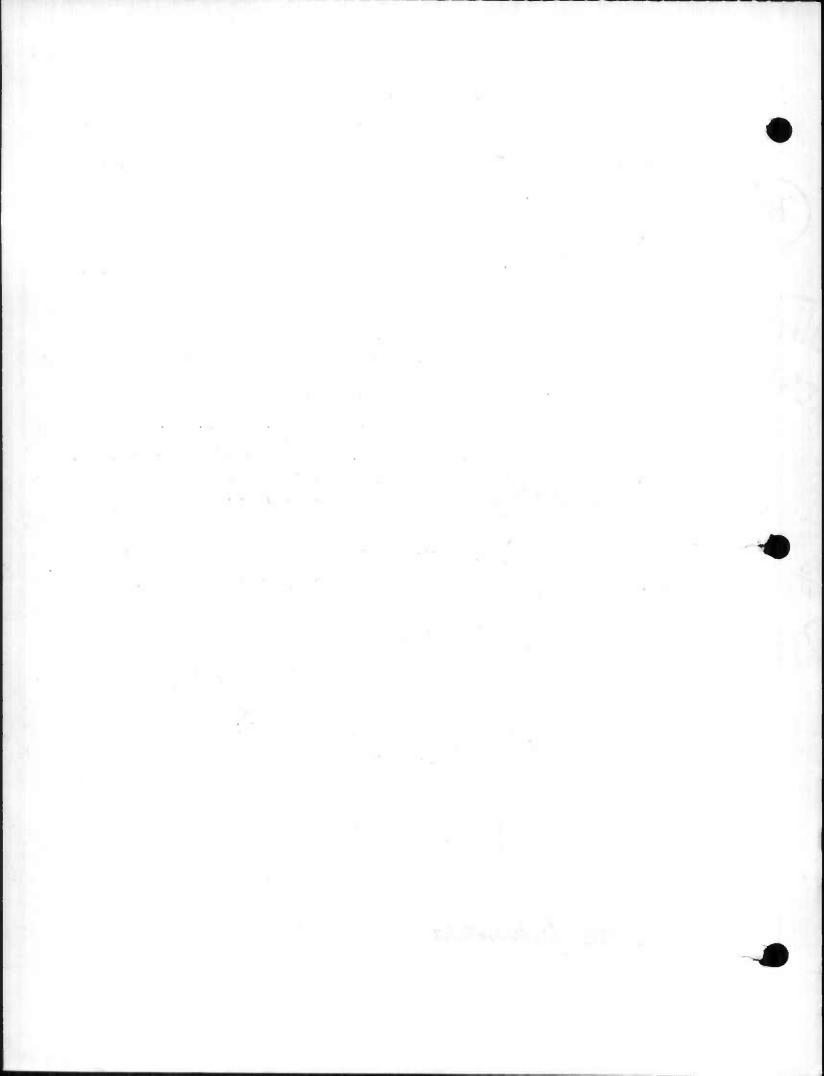
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		TMENT OF I		MENTAL HYGIEN	E	
	4. SOCIAL SECURITY NUMBER 5.	PRIE SI SEX 6. AGE (In yrs	Ay to	OAL IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEATH DO TO DATE OF BURTH	7 199	BIRTHPLACE (State or Foreign
	215-40-7867 1	□ M 2X F 53	YRS.	MONTHS DAYS	HOURS MIN.	July 07,		Maryland
TOR R	Joseph Richey Ho				timore	AIH	9c. COUNTY	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CITY	TOWN OR LOCA	TION			10d, INSIDE CITY
	Maryland N/	/A			Baltim	ore		1 X YES 2 NO
FUNERAL	1410 Anglesea St	treet Apt.	T1	10	1. ZIP CODE 2122	4	,	OF WHAT COUNTRY?
B	11. MARITAL STATUS 12. 1 Never Married 2 Merried 3 Widowed 4 XDivorced	. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	XNO	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexica 2 NO Specify	NIC ORIGIN? (Specify Yes on, Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATH (Specify only highest grade com	apleted)	Give kind of w	USUAL OCCUPATION done during mo	ON ost of working	16b, KIND OF BU	SINESS/INDUST	'RY
MPLE	Elementary/Secondary (0-12) Co	Au	to Wo			Automoti	ive Mar	ufacturer
S	17. FATHER'S NAME (First, Middle, Last) Unknown					ME (First, Middle, Melden	Sumame)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street of		Unknown Route Number, City or Tow	n, State, Zip Coo	(n)
욘	Harry Joseph Saw		1410	Anglesea	a St. Apt	. Tl Balt	imore,	MD 21224
	20e. METHOD OF DISPOSITION 1			F DISPOSITION (No.		20/95 Ba	CATION — CHY	
	21. SIGNATURE OF FUNERAL SERVICE LICENS		onald			ciety of Ma	rvland	Inc
Ш	Dawn F. Mc	Donald		299 F	rederick	Rd. Balti	more, l	MD 21228
	23. PART I. Enter the diseases, or com shock, or heart failure. Liet IMMEDIATE CAUSE (Final disease or condition resulting in death)	plications that ceused the Dnly one cause on each i	lina.		de of dying, suc	h as cerdisc or reapi	ratory srrest,	Approximets Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONDUE TO (OR AS	FOIY SEQUENCE OF	Arres	,			minutes 2 mos
CERT	resulting in death) LAST	Caremon	na -	Stoma	rc4.			6 mes
MEDICAL	PART II. Other significant conditions co	ontributing to death but no	ot resulting in	the underlying	g ceuse given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 -+10
AN:	DID TOBACCO USE CONTRIBUTION OF THE PROPERTY O				UNCERTAIN	V [3]		
PHYSICIAN:	EXAMINER?	OSPITAL: Inpatient 2 ER/Outpatient		OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 POther (Specify)	Habi	ce.
PH	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ	URY AT	28d. DESCRIBE HOW II		
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	280. PLACE OF INJURY — AI	t home, larm, st		YES 2 NO	281. LOCATION (Street o	nd Number or R	tural Route Number
ETEC	4 Homicide determined	building, etc. (Specify)	Salarit S			City or Town, State)		
COMPLETED	2 MEDICAL EXAMINER: O	i: To the best of my knowledge, in the basis of examination and						use(e) end menner as stated.
B	296. SIGNATURE AND TITLE OF CERTIFIER	Swin A	n		29c. LICENSE NUN	IBER		: 19-95.
10	30. NAME AND ADDRESS OF PERSON WHO CO	TYWIN M	TEM 27) (Type, 1	Print) N.Ea	tau SX	, Ba He	.Md.	(201
	OCT 1 9 1995	32. REGISTRAR'S SIGNATUR	E					1 14



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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed withing of hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Cremation. of removal.	IMPORTANT; If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIF	ICALE OF I	DEATH	REG.	NO.		
1. DECEDENT'S NAME (First, Middle, Last)	,	1	SH-		2. DATE OF DEATH	DAY 4	wear	3. TIME OF DEATH
charles w	Smit	5			MONTH LO	17	1995	12:45
		GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		a. BIRTH	PLACE (State or Foreign
138-16-6910	1 M 2 F	81 YAS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Country N.	
9e. FACILITY NAME (If not institution, give stree	et end number)	-96400-00	9b. CITY, TOWN OF	LOCATION OF DE	HTA	9c. COI	JNTY OF D	
University Hos	sp.		Baltin	nore			NZA	
10e. STATE 10b. COUNTY		10c. CITY	Y, TOWN OR LOCATIO	ON				10d. INSIDE CITY LIMITS?
Md. N	I/A	Ba	ltimore	9				1 X YES 2 NO
10e. STREET AND NUMBER		Man .	101.	ZIP CODE		10g. Cl	TIZEN OF W	HAT COUNTRY?
1515 Baltimore	Nationa	al Pike	2	21229				II.S.
	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ER IN U.S. ARMED	If yes, spec		NIC ORIGIN? (Specify in, Puerto Rican, atc. y:		Speci	- American Indian, i, White, etc. fy: a c k
15. DECEDENT'S EDUCAT	TION	16a, DECEDENT'S	USUAL OCCUPATION	N	16b, KIND OF	BUSINESS/IN		aon
(Specify only highest grade co	empleted)	(Give kind of v	work done during most be retired.)	t of working				
6 th	College (1-4 or 5+)	chauf	feur		Mair	tena	nce	
17. FATHER'S NAME (First, Middle, Last)		Ciradi	. I Cui	16. MOTHER'S NA	ME (First, Middle, Me.		nice	
George Henry W:	illiam S	mith			bel Wes			
19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street en		Aoute Number, City or			
Cassie Dorsey								17 Frier
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE				LOCATION -		
1 Donation 6 Other (Specify)	al from State	Arbutus	ther place!		0/21/9			
21. SIGNATURE OF FUNERAL SERVICE LICEN	NEEE	ALDUUUS		D ADDRESS OF FA) ALU	utus	· Ind.
23. PAID Enter the disease, or col				timore,	Md. 21		rreat,	Approximate
shock or heart failure. Lit IMMEDIATE CAUSE Final disease or condition	st only one cause o	on each line.	Balt fot anter the mod	timore,	ch as cardiec or n	espiratory a	rreat,	Interval Batw
shock or heart failure. Lit IMMEDIATE CAUSE Final	st only one cause o	on each line.	Balt fot anter the mod	timore,	ch as cardiec or n	espiratory a	rreat,	Interval Batw
shock or heart feliure. List IMMEDIATE CAUSE Finel disease or condition resulting in death)	DUE TO (DR	AS A CONSEQUENCE OF	Balt Herricans	timore,	ch as cardiec or n	espiratory a	rreat,	Interval Batw
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TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEAD CERTIFICATE OF DE		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	. .	3. TIME OF DEATN
DORIS LENORE SNYDER		OCT 08	1995	11:15 Am
		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign
212 32 7409 1 M 2 X F 77 YRS. MONTHS DAYS HOW	DURS MIN.	01 02 18		nsylvaniua
96. FACILITY NAME (it not institution, give street and number) 1204 FRAILEY WAY 96. CITY, TOWN OR LO BALTIMO			9c. COUNTY OF I	DEATH
RESIDENCE OF DECEDENT				
Md. N/A Baltimore				10d. INSIDE CITY LIMITS?
100. STREET AND NUMBER 101. ZIP	CODE		10a CITIZEN OF	tX YES 2 □ NO WHAT COUNTRY?
1204 - 1-	205		USA	A CONTRACTOR OF THE PARTY OF TH
		C ORIGIN? (Specify Yee o	r No- 14. RAC	E — American Indian,
	Cuben, Mexicen, NO Specify:	, Puerto Rican, etc.)	Spec	othy:
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of a	working	16b. KIND OF BUSIN	NESS/INDUSTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)	working	At Hor	ne	
Unknown				
17. FATHER'S NAME (First, Middle, Lest) Frank B. Snyder		NE (First, Middle, Meiden St n Davis	imame)	
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and No.				
Mary L. Litzau 3107 Greenhill				
20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cematary, crematory or other place) Green Mount Cremat			THO MA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AC	DDRESS OF FACI	ILITY		•
		er & Son I: Ave. Balto		
23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of				Approximata
shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	lionsa	la De	seul	Interval Between Onset and Death
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CAUSE (Disease or Injury that Initiated events resulting in death) LAST				
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO L	UNCERTAIN	I Ken Grec	len	1 120 2 100
25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)			77	
XX YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5	X Residence 6	B Cher (Specify)		
27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? M 1 YES		28d. DESCRIBE NOW INJ	JURY OCCURED	
2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		281. LOCATION (Street end City or Town, State)	d Number or Rural	Route Number,
29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end	place, end due t	to the cause(e) and mann	er as stated.	
one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death				(e) end menner ee stated.
Theodore U. King ms	O.C.M.			09,1995
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) THE UD ORE MILLIF 111 Penn Stre	et, Ba	altimore,	Maryl	and 21201
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

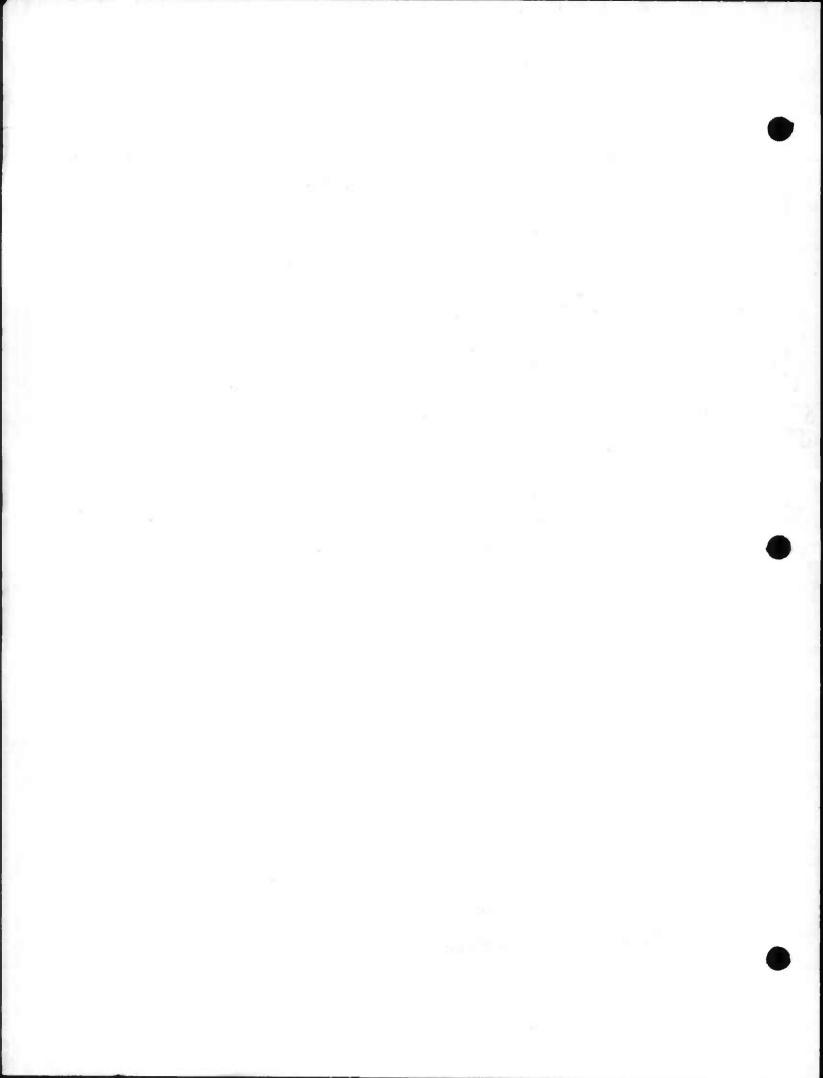
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



IMMEDIATE CAUSE (Final disease or condition resulting in death) A. Respiratory failure Due to (or as a consequence of): Aspiratory Fellow This B. Due to (or as a consequence of): Due to (or as a consequence of):	Foreign
214-40-5928 1	FY
Carroll Co. Gen. Hospital Westminster Carroll RESIDENCE OF DECEDENT Maryland Carroll Vestminster 106. SMATE 106. COUNTY 106. COUNTY 106. COUNTY 107. STREET AND NUMBER 205 St. Mark Way, Apt. 402 11. MARITAL STATUS 1 Marved Married 2 Married 12. Was DECEDENT EVER IN U.S. SPANED 13. WAS DECEDENT OF HESPANIC OFFICIARY (Specify Yes or No. FORCES? 1 YES 2 NO. 1 YES 2 NO. 1 YES 2 NO. 1 YES 2 NO. 1 YES 2 NO. 1 YES 2 NO. 1 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 2 YES 3 YES 3 YES 3 YES 3 YES 3 YES 3 YES 3 YES 4 YES 3 YES 4 YES 3 YES 4 YES	
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Gene into dispersion of highest grade completed College (1-4 or 5+) To	
Trederick Rudolph Struve 19a. INFORMANT'S NAME (First, Middle, Lest) Frederick Rudolph Struve 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zip Code) 20c. METHOD OF DISPOSITION 1	
19b. MAILING ADDRESS (Street and Number or Rural Roune Number, City or Town, State, Zip Code) Mildred Struve 20b. Mark Way, Apt. 402. Westminster, Md. 21' 20b. Mark Way, Apt. 402. Westminster, Md. 21' 20b. Mark Way, Apt. 402. Westminster, Md. 21' 20b. Mark Way, Apt. 402. Westminster, Md. 21' 20b. PLACE AND DATE OF DISPOSITION (Name of Mumber of Pural Street) 10 DATE DATE 20c. LOCATION — City or Town, State 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Mc 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, interval i	
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21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Mc 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval disease or condition IMMEDIATE CAUSE (Final disease or conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or injury that initiated events) The tronor of the resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY 24b. WERE AUTOPSY 24b. WERE AUTOPSY 24c. WAS AN AUTOPSY 24b. WERE AUTOPSY 24c. WAS AN AUTOPSY 24b. WERE AUTOPSY 24c. WAS AN AUTOPSY 24b. WERE AUTOPSY 24c. WAS AN AUTOPSY 24b. WERE AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WAS AN AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WAS AN AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY 24c. WERE AUTOPSY	158
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29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner ea atsted.	stated.
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Yee 297. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Yee	
30. NAMI AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cam Co. Gen - Hospi Cat.	

Pages 1, 2, 3 should

permit.

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W. a 31. DATE FILED (Month)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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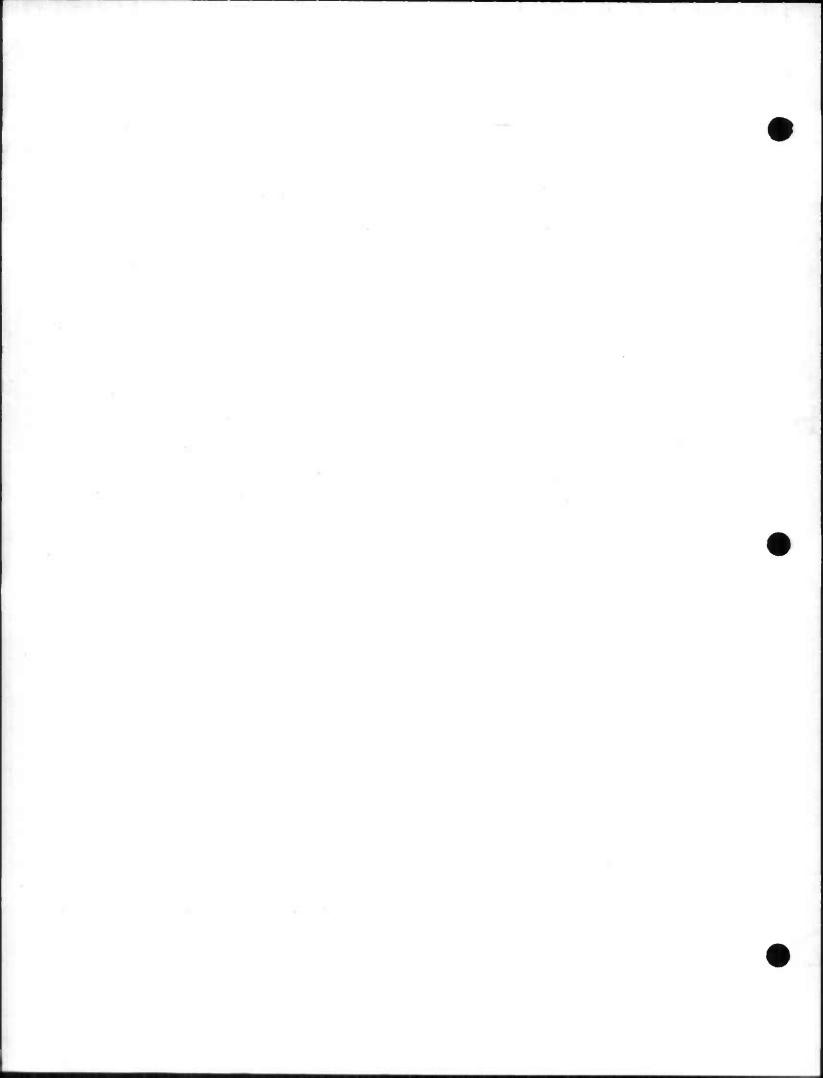
Iteml, Film728, 10/19/95, 1t FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY RICHARD 1995 T TRA SCHOCKET OCTOBER 14 10:40 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 215-50-3590 t 😿 M 2 🗌 F 47 YRS. FEB. 5, 1948 MARYLAND 9e. FACILITY NAME (If not institution, give street and number 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 879 N. HOWARD ST. BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10b. COUNTY toc, CITY, TOWN OR LOCATION toe. STATE 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE t YES 2 THO FUNERAL too. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101 ZIP CODE 2438 SMITH AVE. 21209 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? t YES 2 THO IF YES, GIVE WAR OR DATES tt. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—It yee, specify Cuban, Mexican, Puerto Ricen, etc.) t YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. t Never Married 2 X Married Specify BY 3 Widowed 4 Divorced WHITE ED to. DECEDENT'S EDUCATION ton. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Ш Elementary/Secondary (0-t2) College (t-4 or 5+) COMPL 12 PROPRIETOR HARDWARE 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) **ABRAM** SCHOCKET BE DOROTHY **APPLEBAUM** tes, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 PHYLLIS SCHOCKET 2438 SMITH AVE. BALTIMORE, MD 21209 20a, METHOD OF DISPOSITION 1 & Burlal 2 Cremation 3 Re 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State ANSHE EMUNAH (AITZ CHAIM)-10-18-1995-BALTIMORE, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. NAME AND ADDRESS OF FACILITY 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart feiture. Liet only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Shot Gun wound recuiting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese Dr injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 SYES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DI UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) OTHER:
4 | Nursing Name 5 | Residence | | Other (Specify) | STORE HOSPITAL : YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 28s. DATE OF INJURY (Manth, Day, Year) Farm (28b. TIME OF INJURY (0 - 14 - 9 5 10:30 27. MANNER OF DEATN 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 10:30 M t YES 2 NO Shot Subject BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

£7.9 N | 17/Ward Street 3 Suicide COMPLETED 4 Homicide determined 79 toward 29a. CERTIFIER
(Check only one)
2 V MEDICAL EXAMINED: On the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 💢 MEDICAL EXAMINER: On the basis of exemplastion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ▶OCTOBER 15,1995 O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

Powler

111 Penn Street, Baltimore, Maryland 21201



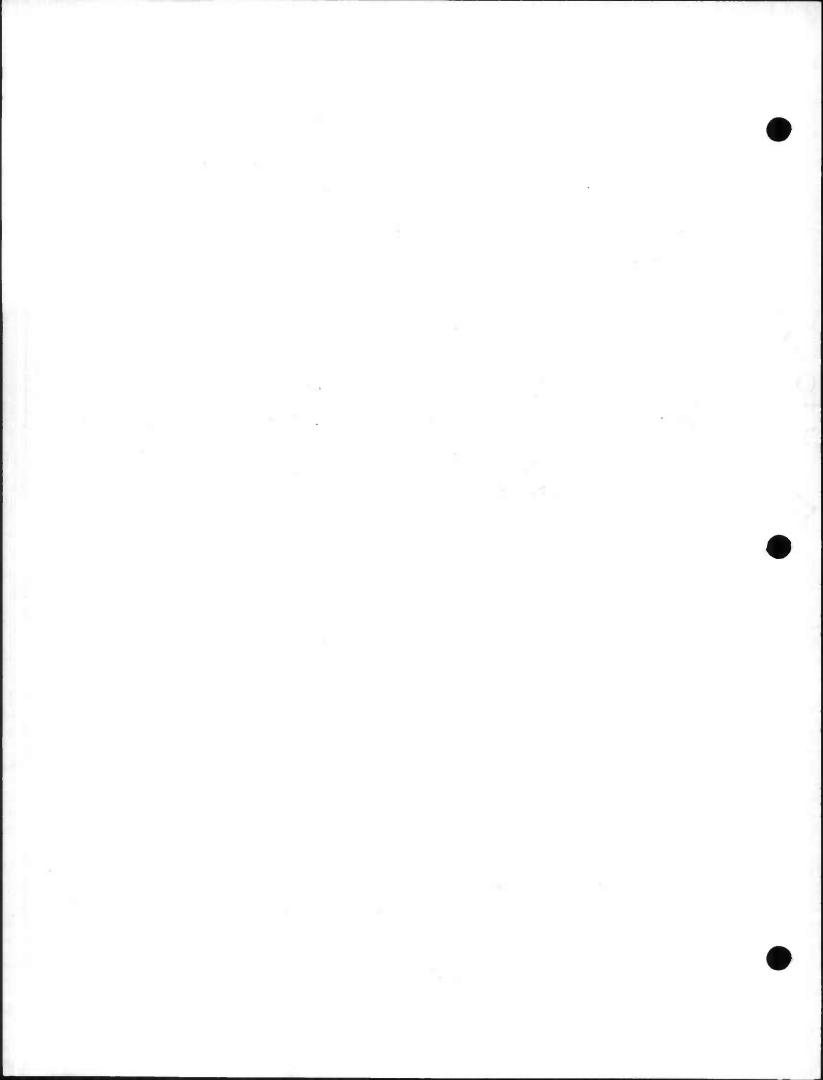
		1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAN	D / DEPARTM			MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		1	. TIME OF DEATH
		DES	PINA		SOF	HOCLE	US	October :	17, 19	995	9:15 A
29		4. SOCIAL SECURITY NUMBER 21620-4878	1 M 2 XF	AGE (In yr	YRS. MON	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	T		LACE (State or Foreign
2. 3 should	OR	90. FACILITY NAME (If not institution, give st Meridian Nursing	eet end number) Center-Han	nmon	ds Lane	Balti	OR LOCATION OF DI		9c. COUN	Arui	
- S		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		_	10c CITY TO	WN OR LOCA	ZION				
mit. Page	L DIRECTOR	Maryland N/A			Baltin	nore				1	INSIDE CITY LIMITS?
an. transit pe	FUNERAL	736 S. Oldham Str					21224		U	S.A	AT COUNTRY?
21215-0020 I or attending physician. for use as the burial-transit permit. Pages	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR (YES 2	NO NO	If yes, sp	CENDENT OF HISPAR Decity Cuban, Mexica 3 2 [C] NO Specifi	NIC ORIGIN? (Specify in, Puerto Ricen, etc.) y:	Yes or No-	14. RACE — American Indian Black, White, etc. Specify: White	
r attend	9	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	164	Give kind of work			16b. KIND OF E	USINESS/INDU	ISTRY	
	COMPLETED	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Illia Do MOT use retired t							
2 8 8 ×	111	17. FATHER'S NAME (First, Middle, Lest) Gregory Luzzi							on Surneme) Unknow	n)	
	TO BE	190. INFORMANT'S NAME (Type/Print) Theodore Sophocle		Evangelia (Unknown) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code) 6584 Brentwood Road, Linthicum, Md. 21090							
		20. METHOD OF DISPOSITION		20b. PL/	ACE AND DATE OF DI				LOCATION — C		
O B m		1 X Suriel 2 Cremetion 3 Remo	val from State	Gre	ek Orthog	lox Ce	emetery	10-20 Ba			,
BALTIMORE, ss after death. Page 6 may be n by the funeral director, page removal. dical examiner must be in		21. SIGNATURE OF FUNERAL SERVICE LICE					ND ADDRESS OF FA			,	
BA Ber de the fundal.	Ш	Inn & m						Ave., Bal			. 21224
filled ir ion. or		23. PART I. Enter the diseases, or c ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition	lat only one cause o	on each	line.			las Cardiac or res		at,	Approximate Interval Between Onset and Deatl
N 8 5 - 6	_	resulting in death)			NSEOUENCE OF):		(caro				413
be e clan for to	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A COI	NSEQUENCE OF):						
Certifical ling phy ygiene g	TIFIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
Pattern mtal H	問										
OR CHARLE	18	PART II. Other algnificant conditions	contributing to dea	th but n	not resulting in the	a underlying	g cause given in		N AUTOPSY ORMED?	A	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
RECO requires the sense signed or Health shows an	ME		perteesi						()		YES 2 NO
	ä	DID TOBACCO USE CONTR	IBUTE TO CAUSI				UNCERTAIN	1			
一年報報馬	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YES	HOSPITAL:			HER:	ne 5 🗆 Residence	6 Other (Specify)			
OF PHYSIC this ce with t	ву РН	27. MANNER OF DEATH 1 Atturel 5 Pending 2 Accident Investigation	28e. DATE OF INJU (Month, Day, Ye		28b. TIME OF INJURY	WC	URY AT DRK? YES 2 NO	28d. DESCRIBE HOV	INJURY OCC	PRED	
TTEND TTEND TTOR: A after 6		3 Suicide 8 Could not be determined	28e. PLACE OF INJ building, etc. (IURY — A (Specify)	At home, farm, street	, lectory, offic				r Rurel Rou	te Number,
_ B 4 2 ₩	COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINES									
THE HOSPITAL THE FUNERAL filled within 72 PORTANT: It		2 MEDICAL EXAMINER	On the observe of examin	- STORT WITE	are investigation, in	my opinion, o			_		
TO THE TO THE DE MINE IN THE THE THE THE THE THE THE THE THE THE	O BE	1 10000	annica				D(9(0 G)	29d. DATE	SIGNED (M	fonth, Day, Year)
5		Michael Schwartz,	M.D., 606	Ham	(ITEM 27) (Typo, Print Monds La	ne, Ba	altimore,	Md. 2122	:5		

OCT 1 9 1995

32. REGISTRAR'S SIGNATURE

	Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	B

	1 - FOR REGISTRAR		MARYLAND /		RTMENT OF				REG. NO				
	1. DECEDENT'S NAME (First, Middle, GLENN	ER	NEST		STRA	USS		2. DA	TOBER	* 15	179795	16:32 P _M	
1	4. SOCIAL SECURITY NUMBER 153-46-1283	5. SEX 1 🔭 M 2 🗌 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YE		IDER 24 HRS	(Mc	re of BIRTH inth, Day, Year) Le 1,19!	52	BIRTHPLACE (State or Foreign Country) NJ		
	9e. FACILITY NAME (If not institution,			9b. CITY, TOWN OR LOCATION OF DEA						9c. COI	UNTY OF DE	Y OF DEATH	
DIRECTOR	3019 GARRIS	SON BLVD		BALTIMORE CITY							N/A	1	
E	10e. STATE 10b. CC			10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?	
	N.J.	Bergen		East Rutherford					7.00			YES 2 NO	
M	10e. STREET AND NUMBER			101. ZIP C			10g. CITIZEN (IAT COUNTRY?			
FUNERAL	19 Grant Stree				0707					USA			
	11. MARITAL STATUS 1 X Never Merried 2 Merried	FORCES?	T EVER IN U.S. AR	MED	If yes	, specify C	ECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— specify Cuben, Maxican, Puarto Rican, etc.)			or No-		14. RACE — American Indian, Black, White, stc.	
B	3 Widowed 4 Divorced	IF YES, GIVE	MAR OR OATES		10	YES 2 D	₹ O Spe	iclly:			Specify	ite	
	15. OECEDENT'S (Specify only highest					ATION	orkina	1	6b. KIND OF BU	SINESS/IN			
COMPLET	Elementary/Secondary (0-12)	Do NOT u	kind of work done during most of working NOT use retired.) Education					n					
§	17. FATHER'S NAME (First, Middle, Las					16. N	OTHER'S	NAME (Firs	I, Middle, Malden	Surname)			
BE (Frederick Stra						lna H						
2	190. INFORMANT'S NAME (Type/Print)		100						imber, City or Tow		,		
	Tracy Strauss 19 Grant Street, East Rutherford, N.J. 07073												
	X Burial 2 Cremation 3 4 Donetion 5 Other (Specify)		Fair I	anodate of disposition (Name of emalory or other place) awn cemetery					DATE 20c. LOCATION — City or Town, State 10/20 Fairlawn, N.J.				
	21. SIGNATURE OF FUNERAL SERVI						DRESS OF		Funeral				
) tistas	4000	Mesos									01000	
	23. PART I. Enter the diseases	or complications th							enue, B			Approximate	
CERTIFICATION	immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	bDUE TO	O (OR AS A CONSE	OUENCE C	0F):							Interval Batween Onset and Daeth	
2	DART II Oshoo significant con	dialogo acceptante at		. Int									
MEDICAL	Chronic D	raauiting	saulting in the undarlying cause givan in Pa				Part i. 24a. WAS AN AUTOPSY PERFORMED?		246.	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 Y YES 2 NO			
	DID TOBACCO USE CO				ES NC		NCERT	AIN 🗹					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:			OTHER:	one)							
1YS	1 XYES 2 NO	1 Inputient 2	ER/Outpatient	28b. TI	4 Numing	Home 5		_		IN HIRW O	0011757		
	1 Natural 5 Pending	Found	Day, Year)	FOU	JURY 1	WORK?	2 NO	<1A	biert	han	4 .	elf	
ВУ	2 Accident Investige 3 Suicide & Could b	28e. PLACE	OF INJURY - At he	me, term,					OCATION (Street				
밀	4 Homicide determine		, etc. (Specify)	me	,			-	altimor Town, Stere	301	9 Gare	ison Ave	
COMPLETED	onel	PHYSICIAN: To the best of	of my knowledge, d	ath occur	red at the time,			due to the	cause(s) end ma	nner as st		end manner es stated.	
TO BE CC	29b. SIGNATURE AND PITLE OF CER	TIFIER A. C.	hutene		restigstion, in my opinion, death occured at the time, date and piece, and $ \begin{array}{c} \text{29c. LICENSE NUMBER} \\ \text{O . C . M . E} \end{array} $					29d. DATE SIGNEO (Month, Day, Year) 199			
ř.	DENNIS CHL		JSE OF DEATH (ITE	M 27) (Typ 11	Penn	Stre	et,	Bal	timore	e, M	aryl	and 2120	
	OCT T 9 1995	Jalia Sauthan	ARIA SIGNATURE							-			



Pages 1, 2, 3 should

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funeral director, page 5 should be detached for use as the burial-transit

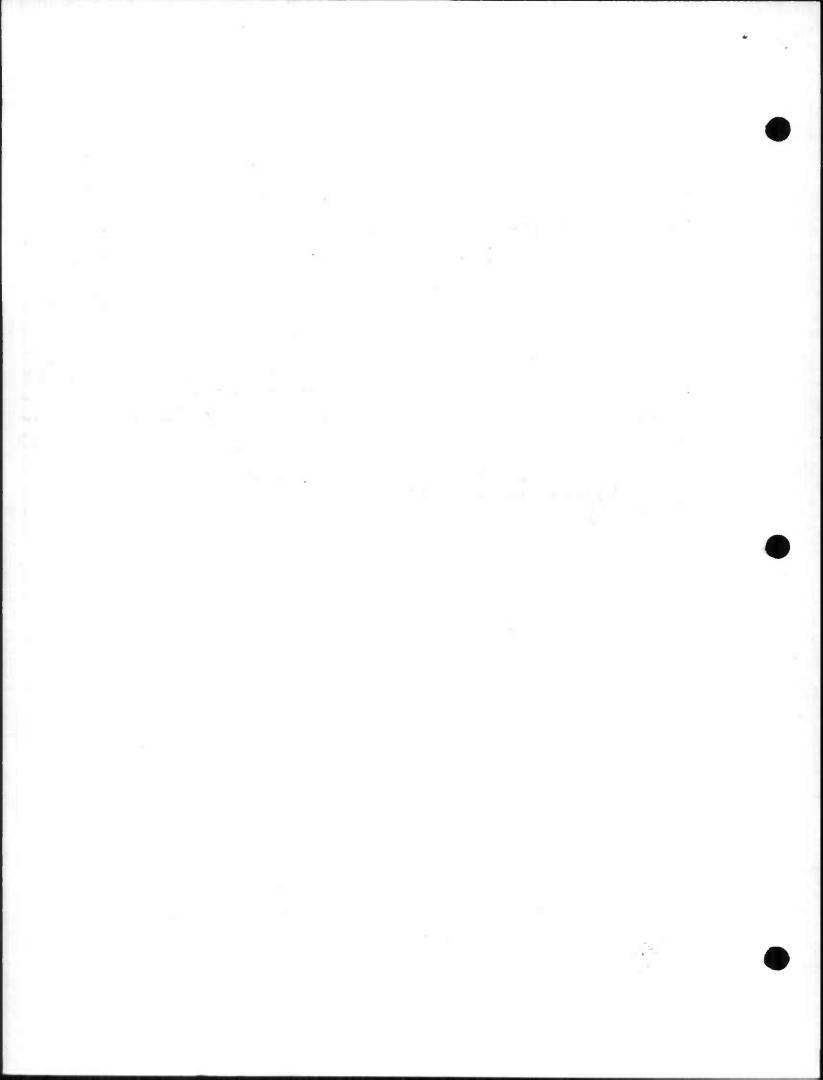
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DIVISION OF VITAL RECORDS, P.O. BOX 6876	CHINACION
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has

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH YEAR SHERRY LYNNE VAUGHN 1995 OCTOBER 8:05 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 3-92-44 1 M 2 X F oct - 14 1962 aware 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR IN REAR OF 4500 EDMONDSON AVENUE BALTIMORE 10c. CITY, JOHN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO 10a. STATE 10h COUNT IA FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE WHAT COUNTRY tog. CITIZEN OF 1024 1229 0 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Juben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American India Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced ac COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY Secondary (0-12) Ver- Worked once. 17. FATHER'S NAME (First, Middle, Last) notified at ume INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (St 2 21229 1024 nelminia alughn must be 20a METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from Stata 20th PLACE AND DATE OF DISPOSITION (Name of Comments) Charactery or distribution in town, mod 4 Donation 8 Other (Specify) examiner DE FUNERAL SERVICE LICENSEE 21. SIGNAT 22. NAME AND ADDRESS OF FACILITY ct Hue)a filled in by the fion, or removal. medical Enfar the discess, or complications that canock, or heart fellure. List only one countries 23. PART I. not enter the mode of dying, such as cardiac Approximate Interval Between **Onset and Desth** IMMEDIATE CAUSE (Final other traumatic event, the cremation. disease or condition Mackiple Sh 5 culting and completely fit o burial, cremation reaulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) the attending physician ar Mental Hygiene prior to if any, leading to immedista cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 23 shows any injury, or PART il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Signed by the PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 OYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO TO UNCERTAIN I PHYSICIAN: 28. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL this certificate his with the State C Hem EXAMINER? OTHER:
4 □ Nursing Home 5 □ Residence XIXOther (Specify) HOSPITAL: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 VACANT LOT 280. DATE OF INJURY (Month, Day, Year) (Fam. 1280. 10-13-95 0 27. MANNER OF DEATH TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation subject 0752 M Shubbed 1 YES 2 NO BY TO THE FUNERAL DIRECTOR: After I be filed within 72 hours after death IMPORTANT: If Item 28 is mar 2 Accident 281. LOCATION (Street and Number or Rural Route Nymber, Salumere 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 8 Could not be COMPLETED 4 Homicide Vacant lot 4500 29e. CERTIFIER (Check only one)

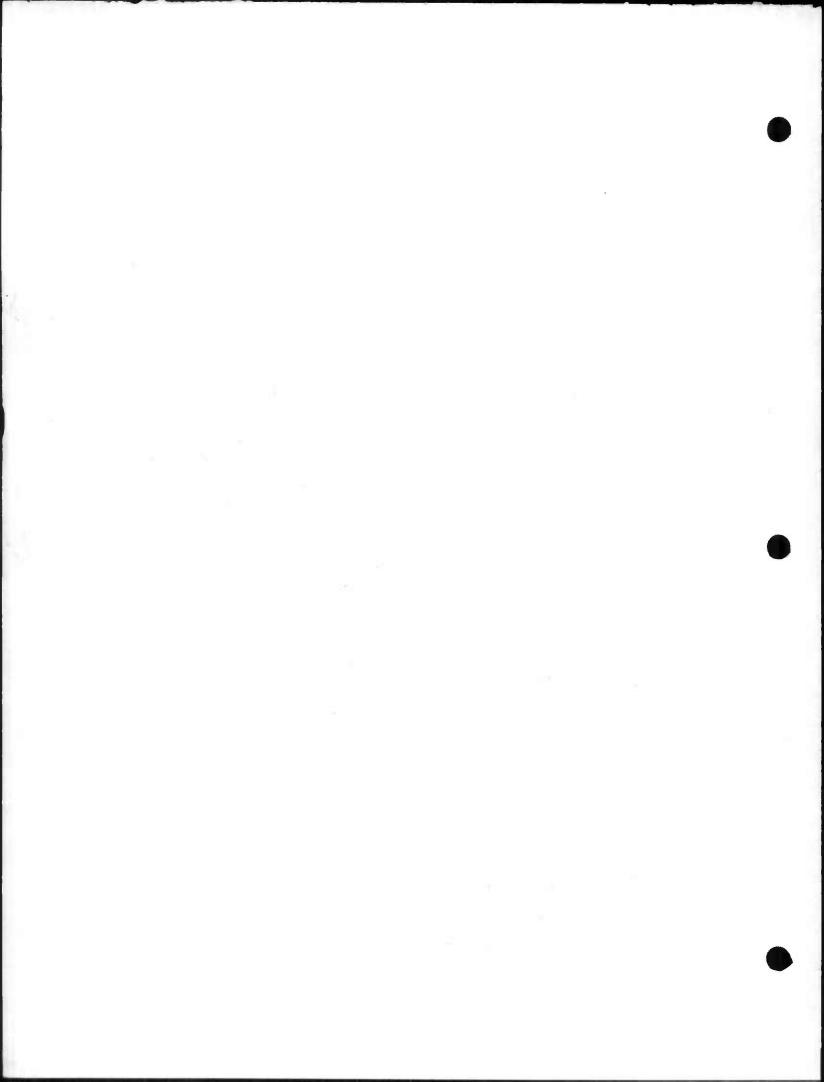
27 MENCAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2X MEDICAL EXAMINER: On the bests of exergification end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCTOBER 14, 1995 O.C.M.E. 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) (wher 111 Penn Street, Baltimore, Maryland 21201



BALTIMORE, MARYLAND 21215-0020	4 hours after death, Page 6 may be retained by the hospital or attending physician,	filled in by the funeral director, page 5 should be detached for use as the burial-transi n, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	TATE OF MARYLA			HEALTH AND	MENT	AL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH		3. TIME OF DEATH
,	Michael N.	Wilson				OCT	-	0 1995	
	4. SOCIAL SECURITY NUMBER 5. S	EX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEA		. 7. DAT	E OF BIRTH	8. Bi	IRTHPLACE (State or Foreign
	215-64-6119 1X 9e. FACILITY NAME (If not institution, give street ex	M 2 F	41 YRS.	9h CITY TOV	8 HOURS MIN.	Ju1	y 9, 19		shington DC
DIRECTOR	2808 Baker Stree				altimore				n/a
E C	10e. STATE 10b. COUNTY		10c. CIT	, TOWN OR LO	CATION				10d. INSIDE CITY
5	Maryland	n/a		Balti	more				LIMITS?
FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN (OF WHAT COUNTRY?
E	2808 Baker Street				21216			USA	1
5		MAS DECEDENT EVER IN I			DECENDENT OF HISP specify Cuben, Mex			or No- 14. F	RACE — American Indian, Black, White, etc.
BY		F YES, GIVE WAR OR DAT			rES 2 X NO Spe		y rireant, etc./		Specify:
	15. DECEDENT'S EDUCATIO	N T	16e. OECEDENT'S	LIGUAL OCCUE	ATION		IN VIND OF BUIL	BINESS/INDUSTR	Black
	(Specify only highest grade comp.	eted)	(Give kind of v	vork done during a retired.)	most of working	["	B. KIND OF BUS	SINE 33/INDUSTR	17
7	11th Grade	lege (1-4 or 5+)	Auto	Mechar	ic		Wabas	h Mobil	es
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					NAME (First	, Middle, Malden		.00
BE C	Bernard L. Rosier				Barba	ra Wa	tson		10.
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	et and Number or Rur	ral Route Nu	mber, City or Tow	n, Stete, Zip Code)
٦	David Smith		2808 E	Baker S	treet	Bal	timore	, Maryl	and 21216
	20a, METHOD OF DISPOSITION 1 N Burtal 2 □ Cremation 3 □ Removal !	20b.F	PLACE AND DATE	OF DISPOSITION	I (Name of	oct		CATION — City of	
	4 Donation 5 Other (Specify)	Ar	ery, crematory or o	emoria.	L Park		18 Bal	timore	County, MD
	21. SIGNATURE OF BONERAL BEHVICE LICENSE	. 1	.1	22, NAM	AND ADDRESS OF	FACILITY N	Jutter	Funeral	Homes, Inc.
	1001/8/1 N	V. Anu	th	Ba1	1 Gwynns timore,	Mary1	and 2	way 1216	
	23. PART I. Enter the diseases, or comp shock, or heart fellure. Liet	licetions that coused	the deeth. Do r	ot enter the	mode of dylng, s	uch ee ca	rdiac or reepl	ratory erreat,	Approximate Interval Between
	IMMEDIATE CAUSE (Finei	1	I line.	. 1					Onset and Death
	diseese or condition resulting in death) e	Gram Nego	tive Bo	cterial	14 DAYS				
					1			FIVE YEARS	
NO N	Sequentially list conditions, Du ACQUIRED TEMMUNOCETICIONY SYNDROME								
¥	If any, leading to immediate cause. Enter UNDERLYING			,	/ /				
Ĕ	CAUSE (Disease or injury that initiated evente	OUE TO (OR AS A	CONSEQUENCE OF	F):	/		1-11		
CERTIFICATION	resulting in deeth) LAST								
	PART II. Other significant conditions co	ntributing to death bu	t not reculting	in the under	ving ceuse given	in Part i.	24a. WAS AN	AUTOPSY	24b, WERE AUTOPSY FINDINGS
CAL	CARDIOMYOPATHY		•		,,		PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
9							1 TYES 2	E NO	OF DEATH?
≥	DID TOBACCO USE CONTRIBU	ITE TO CAUSE OF	DEATH YE	S 🗆 NO	UNCERT	AIN 🗆			TES 2 DAO
Y.	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEA				1		
SIC	EXAMINER? 1 YES 2 NO 1	SPITAL: Inpetient 2 DER/Outpe	tient 3 DOA	OTHER: 4 - Nursing	Home 5 - Reelders	ce 6 🗆 Ot	her (Specify)		
PHYSICIAN: MEDIC	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c	INJURY AT WORK?	28d. D	ESCRIBE HOW I	NJURY OCCURE	D
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY - building, etc. (Specif	— Al home, ferm,	atreet, fectory,	office		CATION (Street of ty or Town, State)	and Number or Ru	ural Route Number,
Ë	290. CERTIFIER 1 CERTIFYING PHYSICIAN:	To the best of my knowle	dge death occurr	ad at the time	date and place, and o	due to the c	euss(s) and mar	ner se stated	
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On								use(e) end manner es stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE I	NUMBER		29d, DATE SIG	INED (Month, Day, Year)
BE	Slan L. With	toin M. D.			0447	68		D 10/	18/95
2	30. NAME AND ADDRESS OF PERSON WHO CO		ГН (ITEM 27) (Туре	, Print)					
	ILAN S. WITTSTEIN	1830 €.	MONUM	ENT S	T. 9th Fl	200	DALT.	MD.	21205
	31. OCT 1 9 1995 Juli	32 REGISTRAR'S NGNA	TURE						



	Pages	
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attending	use as the	
nospital or	ched for use	
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ffer death	the fund	_,
hours a	lled in by	1, or removal
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De exec	cian and	or to bu
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quires	n signed	Health

BALTIMORE, MARYLAND 21215-0020

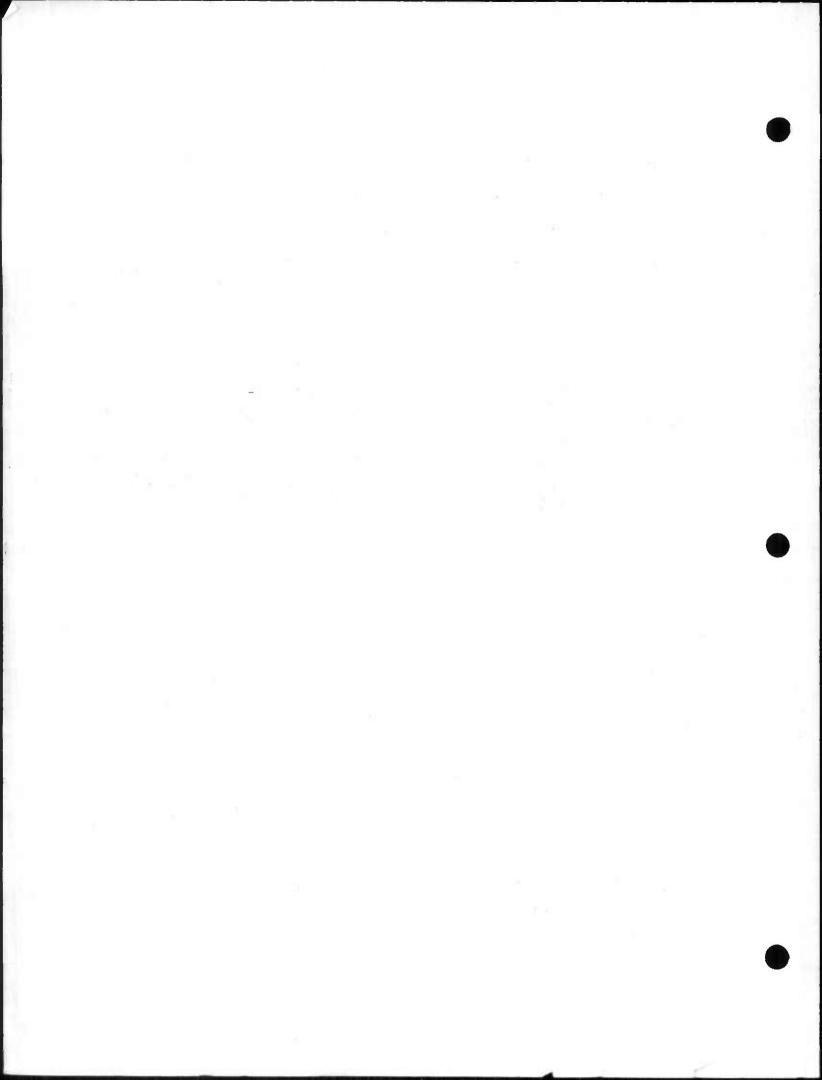
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

EOR	PARI 1, 2/,							LAUD I	MENTAL III	/01EH	900	J	01440
1 - STATE REGISTRA		STATE OF W			ICATE				RE	G. NO.	<u> </u>		
1. DECEDENT'S DAVII	NAME (First, Middle, Last) D BRYAN	Т			W.	ARD)		2. DATE OF DI MONTH OCTOBI	ER DA	Š, 1	995	3. TIME OF DEATH 9:35 A
4. SOCIAL SECU	RITY NUMBER	5. SEX	8. AGE (In yrs. I		IF UNDER 1 Y	\rightarrow	IF UNDER 24	4 HRS. MIN.	7. DATE OF Bil (Month, Day,	RTH Year)		Count	
	= 4UD1 ME (If not institution, give		- 0.		9b. CITY, TO	OWN OF	LOCATION	N OF DE		23_1	963 9c. COU	MAF NTY OF E	RYLAND DEATH
2108 I	MCCOLLOUP OF DECEDENT	STREET			BA	LTI	MORI	E C	ГТҮ		N	/A	
2108 DESIDENCE 100. STATE MARYLAN	D 10b. COUNT	Y/A			TY, TOWN OR LOCATION ALTIMORE CITY							10d. INSIDE CITY LIMITS? 1 V YES 2 NO	
	ET AND NUMBER					101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?		
	1226 N. Washington Street 21213 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC						NIC OBIOINIZ /P-	all. Va		S.A.			
1 /	1X Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES					13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:					Blac	E — American Indian, ck, White, atc. city: BLACK	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) 10th grade 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Laborer 15a. DECEDENT'S USUAL OCCUPATION (Give kind of working life. Do NOT use refired.) 15b. KIND OF BUSINESS/INDUSTRY Construction							DLACK					
17. FATHER'S NA	ME (First, Middle, Last) McLaughliu								ME (First, Middle,	Maiden .	Sumame)		
	'S NAME (Type/Print)						d Number o	or Runal	A 1 1 7 Route Number, Ch				
Ava Moi								, Ba	altimor				21215
1 🗆 Buriel 2	Cremation 3 Ren 5 Other (Specify)	noval from State	cemetery, c	crematory or o	other place)				1				Maryland
21. SIGNATURE	OF FUNEBAR SERVICE L	CEMPLES		700	22. NA	ME AN	ADDRESS		ROWN COI				, Mary Lanu
,	110	Olacer	<u></u>	-	12	06	W. No	nrth	Avenu	٩			
IMMEDIATE C disease or co resulting in d	ndition	NARCOTIC	se on each li	na. DHOL IN	TOXICAT		e or dyin	g, suc	n as cardiac c	or respi	ratory ar	rest,	Approximate interval Between Onest and Dast
Sequentially If any, leading cause. Entar CAUSE (Disea	se or Injury	с	(OR AS A CONS										
Sequentially if any, leading cause. Enter CAUSE (Diseath that initiated resulting in d		d	(OR AS A CONS	SEQUENCE O	F):								
	r significant conditio	ne contributing to	daath but no	t resulting	in the unde	arlylng	causa gl	ven in		WAS AN PERFOR	MED?	24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOB	ACCO USE CONT	RIBUTE TO CA			ES N		UNCE	RTAI	NX				1 120 2 NO
25. WAS CASE R EXAMINER? 1 XYES	EFERRED TO MEDICAL	HOSPITAL:			OTHER:		5 WRas	idence	8 Other (Spe	nciful.			
	5 Pending	28a. DATE OF (Month, D	INJURY	28b. TIN	IE OF 20	Bc. INJU WOF	IRY AT		28d. DESCRIB	E HOW I	NJURY OC	CURED	
2 Acciden 3 Suicide 4 Homicic	8 XXCould not be	28s. PLACE O	F INJURY — At etc. (Specify)			_	700		28f. LOCATION City or Tow	(Street a	2108		Route Number, JLLOH ST.
29a. CERTIFIER (Cheek only		SICIAN: To the best of	my knowledge,	death occur						and mar	vner as sta		
	AND TITLE OF CERTIFIE	1	xamination and/	or investigate	on, in my opii	nion, de	ath occure			placa, an			(a) and manner as stated. D (Month, Day, Year)
717	no	whe	M)			0415406403	C.M				OBE	
JULI	TOW U	HO COMPLETED CAUS	SE OF DEATH (I			ree				ا . م			d 21201
31. DATE FILED	Month, Day, Year) 1 9 1995	fulla al funda	AT SIMINTURE	4							Y		



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

sp											
TIEMS: 23 PART 1, 27,								•	15	3 4 4 6	
FOR STATE REGISTRAR	STATE OF MA				HEALTH AND	MENTA	REG. N				
1. DECEDENT'S NAME (First, Middle, Last) WILLIE		WILSO	N			2. DATE MONT OCT	OF DEATH	™ 16 1	995	3. TIME OF DEATH 2:16 P	
	1 X M 2 □ F	4 2		MONTHS DAYS	HOURS MIN.	7. DATE (Mon A P I	OF BIRTH	,195	a. BIRTH Countr 3 SC	DUTH CAROL	
	st.	baltimore cit						CAIN			
MARYLAND 106. COUNTY	/ A		10c. CITY	, TOWN OR LOC BAL	TIMORE					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 40 N. BENIALOU 11. MARITAL STATUS 1 Mever Married 2 Married	STREET	EET 2122							OF A.		
3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAR	EVER IN U.S. AF YES 2 R OR DATES	BMED NO	If yes,		ean, Puerto Rican, etc.)			Black	14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. OECEDENT'S EDUCAT (Specify only highest grade co. Elementary/Secondary (0-12) N / A 17. FATHER'S NAME (First, Middle, Last)		(C)	Give kind of w e. Do NOT us		WORKER			BUSINESS/IND		BALTO. C	
17. FATHER'S NAME (First, Middle, Last) ALEX WILSON	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname)										
D INFORMANT'S NAME (Type/Print)	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								21215		
200 METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al trom Stata			her place)		21/	7E 20c.	LOCATION —	ORE	, MARYLAND	
21. SIGNATURE OF THE BANK SERVICE LICE	LEW	IS. T.	GWY	ATAT 22 NAME	AND ADDRESS OF C	ACILITY					
- October 1	July 7 PM			7.6	MTO T.	GMTI					
23. PART i. Entar tha diseases, or cor shock, or heart fellure. Lie IMMEDIATE CAUSE (Finel disease or condition resulting in death)	mplications that at only one cause	caused the de e on each line	cation	45	17 PARK	HE	IGHT	SAVE	. B	ALTO., MD. Approximate Interval Batween Onset and Death	
shock, or heart fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	NARCOTIC DUE TO (C	caused the deep on each line	CATION COURNCE OF	45 oot entar the n	17 PARK	HE	IGHT	SAVE	. B	ALTO., MD. Approximata Interval Batween	
immediate cause (Finel disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	NARCOTIC DUE TO (C	INTOXIC INTOXIC OR AS A CONSE	EQUENCE OF	ot entar the n	17 PARK	HE.	IGHTS diac or re	S AVE spiratory srs	. B	ALTO., MD. Approximate interval Batween Onset and Death Onset	
shock, or heart fellure. List is shock, or heart fellure. List is shock, or heart fellure. List is shocked as a shock of the cause of conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other aignificent conditions	NARCOTIC DUE TO (C) DUE TO (C) Contributing to d	INTOXIC INTOXIC OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE	CATION COURNE OF EQUENCE OF	ot entar the n	17 PARK	HE.	IGHTS diac or re	S AVE spiratory sri	. B	ALTO., MD. Approximate Interval Batween Onset and Death Onset	
shock, or heart fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisily list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions	NARCOTIC DUE TO (C DUE TO (C DUE TO (C) DUE TO (C) DUE TO (C) DUE TO (C)	INTOXIC INTOXIC OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE	EQUENCE OF	ot entar the n i): i): ii): NO iii) (Check only on OTHER: 4 Nursing He	IT PARK node of dying, such	HE.	24a. WAS PERI 1 (YES	AN AUTOPSY COMMED?	B great,	ALTO., MD. Approximate Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset	
shock, or heart fellure. List immediate cause or conditions as a sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRICT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 2 Accident investigation	NARCOTIC DUE TO (C DUE TO (C DUE TO (C DUE TO (C)	INTOXIC INTOXIC INTOXIC OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE	CATION COURNEE OF COURNEE OF COURNEE OF COURNEE OF COURNEE OF OEAT 3 □ DOA □ 28b. TIMM INJ 2:04	The state of the s	UNCERTAL O O O O O O O O O O O O O	HE. Part I. 8 Oth 28d. DE UNKN 26t. LO	24a. WAS PERIOD I (Specify) 1 (Specify) 1 (Specify) 1 (Specify) 1 (Specify) 1 (Specify) 1 (Specify) 1 (Specify)	AN AUTOPSY COMMED?	24b	ALTO., MD. Approximate interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O	
shock, or heart fellure. List immediate cause or conditions as a sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRICT S. WAS CASE REFERRED TO MEDICAL EXAMINER? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Netural 5 Pending investigation investigation	NARCOTIC DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C)	INTOXIC INTOXIC INTOXIC INTOXIC OR AS A CONSE	CATION EQUENCE OF EQUENCE OF resulting I ATH YE ICE OF DEAT 3 DOA 28b. TIMM 2:04 OOMe, form, a	The underly of the un	IT PARK node of dying, such ing ceuse given in UNCERTAL e) The second of the second	HE. Part I. S Oth 28d. DE UNKN 28t. LO C/r/ 40 N	24a. WAS PERI 1 EYES ON N CATION (Street or Town, St.) BENT	AN AUTOPSY CORMED? 2 NO W INJURY OCH Well and Number and Number and Number and Number and Number	24b	ALTO., MD. Approximate interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O	

5. WAS CASE REFERRED TO MEDICAL	HOSPITAL: OTHER:			
EXAMINER? 1 X YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3			8 Other (Specify)
7. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED

29b.	SHRITURE AND TITLE OF ORNTIFIER	
1	Mousine Mr. Mall	
(2	DODGE THE THE CONTROL	
30. N/	AME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type,	Print

100050 W 111 Penn Street, Baltimore, Maryland 21201

HAMAGINA 31. DATE FILED, MORIT, DON YOU OCT 1 9 1995 91995

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th. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

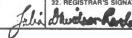
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1	-	FOR STATE REGISTRAR	STAT

TE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		U	ENTIF	ICATE	OF	DEATH		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	HITE						2. DATE OF MONTH	DA		YEAR Q	3. TIME OF DEATH 1: 15 AM
	DONALD E. N.		AGE (In yrs. les	et Printhelmuk	IF UNDER 1	VEAR	IF UNDER 24 HRS.	7. DATE OF		6	43	LACE (State or Foreign
	218-26-4170	1 🔀 M 2 🗆 F	65	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, L	Day, Year)	0	Country	
	Ba. FACILITY NAME (If not institution, give st Bayview Medical (imore	EATH		9c. COUNTY OF DEATH		
DIRECTOR	RESIDENCE OF DECEDENT	Jenter			п	all	THOLE				N/A	
JE I	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OF	R LOCAT	ION					10d. INSIDE CITY LIMITS?
		imore		1	Dunda	-						1 XES 2 NO
FUNERAL	100. STREET AND NUMBER					100	ZIP CODE			10g. CIT	IZEN OF WI	HAT COUNTRY?
ÿ I	7830 E. Collingham				1	1	21222			-	JSA	
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12, WAS DECEDENT EV FORCES? 1 1 IF YES, GIVE WAR	YES 2 1		11	yes, sp	ENDENT OF HISPAI scify Cuban, Maxica 2 XNO Specif	in, Puerto Ric		or No—	14. RACE Black, Specify	— American Indian, White, atc.
- 4		USN										white
TE	15. DECEDENT'S EDUC (Specify only highest grade		(G	ECEDENT'S live kind of a Do NOT us	vork done di	CUPATIO uring mo	ON st of working	16b, K	IND OF BUS	SINESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (0-12) Q	College (1-4 or 5+)		pe M					Sparr	oure 1	Point	
WC	17, FATHER'S NAME (First, Middle, Lest)			pe m			18. MOTHER'S NA		_		OTHE	
	Donald Alton Whit	e						le Ali			an	
BE	19a, INFORMANT'S NAME (Type/Print)						nd Number or Rural	Route Number	City or Tow	n, State, Zij	p Code)	
2	Alice White			7830	E. C	011:	ingham D	rive,	Dund	alk,	Md.	21222
	20a, METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Rem	ovel from State	20b. PLACE	AND DATE	OF DISPOSI	TION /Na	me of	DATE		CATION -	City or Tov	rn, State
	4 Donation 5 Other (Specify)		Chesa	peake			ory		Bel:	tsvil	lle.	Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	O. A	Δ.		Bra	ad1	ey Ashto	n Fune	eral 1	Home	Inc	
	Tulend.	Molla	11/00	110	21:	34 1	Villow S	pring	Road	Dur	ndalk	
	23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Final				not enter	the mo	de of dying, suc	ch ee cerdle	c or reep	ratory er	rest,	Approximete interval Between Onset and Death
	disease or condition resulting in death)	n	YEMA									INK
			AS A CONSE		F):							2 WK
NO N	Sequentially list conditions,		AMON		n:							211
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		LARY NO EAL CA- DUE TO (OR AS A CONSEQUENCE OF):									243
E	CAUSE (Disease or injury that initiated events	DUE TO (OF	AS A CONSE	OUENCE O	F):							
E	resulting in death) LAST	d										
	PART II. Other significant condition	s contributing to de	ath but not	resulting	in the un	deriyin	g cause given in	Part i. 2	4a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL								1	PERFO			AMILABLE PRIOR TO COMPLETION OF CAUSE
									YES 2	_ NO		OF DEATH?
2	DID TOBACCO USE CONTI	RIBUTE TO CAUS	SE OF DEA	ATH Y	SM	10 E	UNCERTAI	ND				
AN	25. WAS CASE REFERRED TO MEDICAL				TH (Check o							
SIC	EXAMINER?	HOSPITAL:	R/Outpatient	3 DOA	OTHER		ne 5 🗆 Rasidenca	6 Other	Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INS		26b. TIR		28c. IN.	JURY AT DRK?		RIBE HOW	NJURY OC	CURED	
ВУ	Netural 5 Pending Investigation	(М		YES 2 NO					
ED	2 Accident 3 Suicide 8 Could not be building, atc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office 28f. LOCATION (Street and Number or Rural City or Town, State)								er or Rumal A	oute Number,		
E	29a. CERTIFIER , CERTIFYING PHYS	ICIAN: To the best of my	knowledne d	laeth occur	rad at the th	me dete	and place, and du	e to the cause	n(a) and ma	nner sa etr	etad	
COMPLET	CONSTRUCTION OF THE STATE OF TH											and menner as stated,
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and ment of the cause (a) and ment of the cause (b) and ment of the cause (b) and ment of the cause (c) and the							(Month. Day, Year)					
H	(Savel PIXTO	well m	0				95015	-		•	10/16	h5
임	30. HAME AND ADDRESS OF PERSON WE	O COMPLETED CAUSE	OF DEATH (IT)	EM 27) /3yo	e. Printi		10010				,	1.5
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE									
	OCT 1 9 1995 1	hi dudent	anlett									





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CZ.		
ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, p		
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in	s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
9	fee.	
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1.5.1	(/)	

DIVISION OF VITAL RECORDS, P.O. BOX 6876

1. DECEDENT'S NAME (Fir	st, Middle, Last)		C						OF DEATH		14.0	3. TIME OF DEATH	
MYRTLE		ANCARROW					Oct 17 1995			11:50 am			
4. SOCIAL SECURITY NUM	IBER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER 1 YEA		R 24 HRS.		OF BIRTH h, Day, Year)			IPLACE (State or Foreign	
212-07-170		1 M 2 X F	80	YRS.	MONTHS DAY		MIN.	De	c. 18	191	4 M	läryland	
the same of the sa	eph Med	reet and number) fical Cente	r		96. CITY, TOW	N OR LOCATE					Baltin		
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Maryland		N/A			ltimor	e City	_					LIMITS?	
4613 Valle		Ave.				10f. ZIP COD	≥ 21206	5		-	U.S.	A.	
11. MARITAL STATUS 1 X Never Married 2 C 3 Widowed 4 Di		FORCES?	NT EVER IN U.S. AI 1 YES 2 X WAR OR DATES		If yes	DECENDENT (specify Cubiness 2 NO	en, Maxica	n, Puerto I	t? (Specify Yes Rican, etc.)	or No—	14. RAC Blac Spec	E — American Indian, k, Whita, etc.	
	CEDENT'S EDUC		18a. Di	ECEDENT'S	USUAL OCCUP	ATION	lna	16b	. KIND OF BU	SINESS/INC	DUSTRY		
Elementary/Secondary 12 yr S		College (1-4 or 5	+)	Owner	se retired.)	most or work	ing		Paper	Box	Co.		
17. FATHER'S NAME (First,		4.							Middle, Malden				
Walter		fton	Ancar	row		Ar	nna	F	•	Ca	rter		
190. INFORMANT'S NAME Mrs. Dorot		erry	19		Loch				imore,			9	
20a, METHOD OF DISPOS 1 X Burlel 2 Creme	ITION	ovel from State	20b. PLACE cemetery, cr		OF DISPOSITION	(Name of	-	DAT	E 20c. LO	CATION -	City or To	own, State	
4 Donetion 5 Doh	er (Specify)			PARKI	NOOD O	ctobei	r 20.	, 199		altim			
21. SIGNATURE OF FUNER													
· Paul	L. Ha	tock	L. Hartso	ck,Jr.	Lec		J. R	uck,	Inc.	5305	Har	yland 21214 ford Rd.	
23. PART I. Enter the	diseasea, or cheart fallure.	complications in List only one ce	L. Hartso at caused the d use on each lin	ck,Jr.	Leconot enter the	nard mode of dy	J. R	uck,	Inc.	5305	Har	ford Rd. Approximate interval Between Onset and Des	
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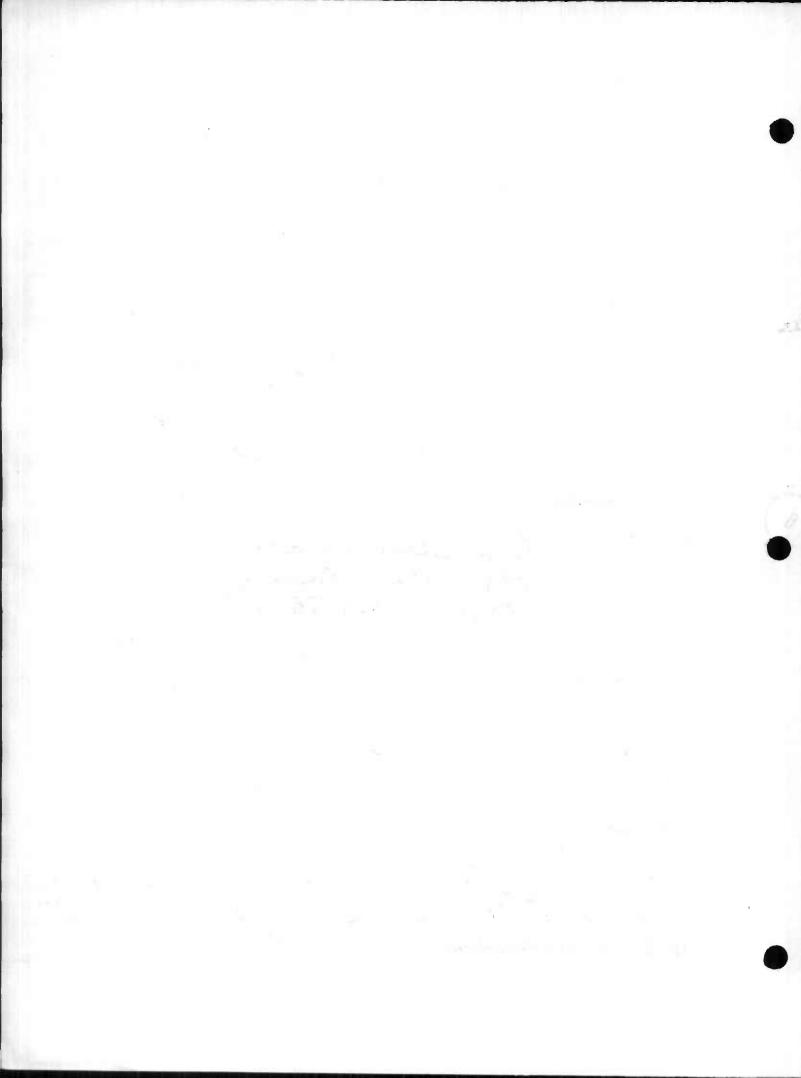
THE RESIDENCE OF SECTION AND ADMINISTRATION AND ADM

RESERVOISE FOR ADDESY FORCE RESERVOISED DOMESTIC

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a few man and the foreigned by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compared for the first manner of freedor, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, command, the months of the state Dept. of Health and Mental Hygiene prior to burial, command.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIV	TO THE HOSPITAL OR AT	TO THE FUNERAL DIRECT DE filed within 72 hours	IMPORTANT: If item

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEOENT'S NAME (First,	Middle, Last)								2. DATE OF DEATH	AV		. TIME OF OEATH
	Lorine	& AGE (in ure la	Babst GE (In yrs. lest birthday) FUNDER 1 YEAR FUNDER 24 HRS.					Oct. 19		7:02p M ACE (State or Foreign			
	578-34-2274 1□M2対F			71	MON			HOURS	MIN.		ept.8,1924 Wash		gton, DC
E .	9a. FACILITY NAME (II not in Annapolis	ion Ct:	r.		napo		TION OF DI	EATH	9c. COUN	ne A	rundel		
E	RESIDENCE OF DEC	EDENT											
DIRECTOR	MD	Anne	Arunde	1		r, TOWN C			ne.	Annapol	is		Od. INSIDE CITY LIMITS? VYES 2 NO
	10s. STREET AND NUMBER	-						ZIP COI		Time Po-			AT COUNTRY?
ERA	325 Cedar	Lane						214	103		USZ		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		FORCES? 1	IT EVER IN U.S. AF YES 2 X MAR OR DATES			If yes, sp	ecity Cub		NIC ORIGIN? (Specify Year, Puerto Rican, etc.) y:	a or No-	14. RACE - Black, V Specify:	- American Indian, White, etc. White
ED		EDENT'S EDUC			CEDENT'S				do e	16b. KIND OF BU	ISINESS/IND	USTRY	
COMPLET	Elementary/Secondary (0		College (1-4 or 5	116	No kind of w Do NOT us	e retired.)	aunng mo	St OF WORK	ang	Medic	al		
W	17. FATHER'S NAME (First, M	iddle, Last)	-		`			10. MO	THER'S NA	AME (First, Middle, Maider			
BE C	Herbert Ed		s							Penn			
10 B	Linda Sul									Route Number, City or Ton Harwood,		207	76
	20a. METHOD OF DISPOSITI	ION	oval from State	20b. PLACE	AND DATE O	OF DISPOS	SITION (Ne	me of		OATE 20c. LC	CATION -		
	4 Donation 6 Other	(Specify)		Mary	Lanc		_				cowns	vill	e, MD
	21. SIGNATURE OF FUHERA	SERVICE LIC	S No.			H	ard	est		uneral Ho			
	23. PART I. Enter the d	(M.V.	S- (O)	My	ath Do s					Ave. Ann			D 21401
		eart fallurd.	a. B	euse on each line	ton			1			metory en		Interval Between Onset and Death
CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
EDICAL C	PART II. Other significa	resulting in the underlying ceusa given in Part					Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 PS 2 5 NO			VERE AUTOPSY FINDINGS MALABLE PRIOR TO COMPLETION OF CAUSE DE DEATH?			
Σ	DID TOBACCO U	SE CONT	RIBUTE TO CA	AUSE OF DEA	ATH YE	s 🗆	NO F	1 UN	CERTAI	NØ		1	YES 2 NO
AN	25. WAS CASE REFERRED T				CE OF DEAT	TH (Check	only one)						
SIC	EXAMINER?		HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHE NU	B: Ising Hon	ne 5 🗆 1	Raaldenca	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	Pending	28e. DATE O (Month,	F INJURY Day, Year)	28b. TIM	IE OF JURY M	W	JURY AT ORK? YES 2	□ NO	28d. OESCRIBE HOW	INJURY OC	CURED	
ED BY	2 Accident 3 Suicide 6 4 Homicide	Could not be determined		OF INJURY — At h	ome, farm,	straet, fac				28f. LOCATION (Street City or Town, State		or Rural Ro	ute Number,
ET	M. CENTIFIED 1												
COMPLETED	(Check only		_							e to the cause(s) and me time, data and place, s			and manner as stated.
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIE	R 77	7				29c. LI	CENSE NU	IMBER	29d, DAT	E SIONED	Month, Day, Year)
TO B	Tener	0-1	mel		mo	Policy		.5	131	778		12/=	26188
_	30. NAME AND ADDRESS O	A F	11LLK	THE OF BEATH (IT)	EM 27) (Type		6/	10,	~ ~	the	My	7-6	100
	OCT 2. 0 1995		32. REGISTR	AR'S SIGNATURE				-	0			9	
	OCT 2 0 1995	1200	* In marrier	Markett									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	TILGIOTTATI		- OL	-CHIE	CALE	UL	DEAL	l III		REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last) DAULD BRISCOE									2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH OF THE STATE O				
	4. SOCIAL SECURITY NUMBER 216-50-4418	1 💢 M 2 🗌 F	or real for your man americal			UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.			MAY 10 1949			Country	BIRTHPLACE (State or Foreign Country) Marvland	
OR	90. FACILITY NAME (If not institution, give a SINAI HOSF	PITAL			9b. CITY	BAL	TYMO	ON OF DE	ATN CI	TY	9c. COU	nty of DE	ATN	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v			, TOWN C									
- DIRECTOR		I/A			Balt	imor	е						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	3209 WINDSOR	AVENUE				101	. ZIP CODE		216		10g. CITI	ITED	STATES	
B	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2 VI	MED	- ['	I yes, sp	ENDENT O	F NISPAN n, Mexicar Specify	n, Puerto I	? (Specify Ye Ncan, etc.)	or No	14. RACE Black, Specify	- American Indian, White, etc.	
윤	15. DECEDENT'S EDU (Specify only highest grade		16a. DEG	CEDENT'S I	USUAL O	CCUPATIO	ON st of workin	in a	16b.	KIND OF BU	SINESS/IND	DUSTRY		
COMPLETED	Elementary/Secondary (0-12) 10 th	College (1-4 or 5+)	Ho.	SABL	retired.)		ORER			va	rious	tr	ades	
BE CO	17. FATHER'S NAME (First, Middle, Leat) GEORGE CETHAN	4 CHEATAM					18. MOTH	DEL	ORES	Melden BRI	Sumeme) SCOE			
TO B	19a. INFORMANT'S NAME (Type/Print) FRANCES GA	ANSE	19b	MAILING 320	ADDRESS	(Street e	OSOR	or Rurel A	NUE,	BALT	I MORE	, MD	# 16	
	29a_METHOD OF DISPOSITION 1 1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	206. PLACE A	ND DATE O	F DISPOS	ITION/Na	me of	ARK	10-		CATION -		n, State MARYLAND	
	21. SIGNATURENCE FUNERAL SERVICE LIC	ZENSEE L	ANDO	4	22.	NAME AN	D ADDRES	S OF FAC	HITY	1101			AVENUE	
\dashv	23. PART I, Enter the diseases, or	complications that	aused the dea	ath. Do no									1 Approvings	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. PNE	on each line.	JA									Approximate Interval Between Onset and Death	
ATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	R AS A CONSED	A CONSEDUENCE OF):								9			
	PART II. Other aignificant condition	a contributing to de	ath but not m	aultina la	the up	doelylae		luca la f	Don't I					
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO									WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
2	DID TOBACCO USE CONTI	RIBUTE TO CAUS	SE OF DEAT	TH YES	1 0	10 🗵	UNC	ERTAIN					YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			OF DEATH	H (Check o	only one)								
XSI	1 YES 2 NO	HOSPITAL:	R/Outpatient 3		OTHER		5 🗆 Res	sidence (6 🗆 Other	(Specify)				
BY PH	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF IN. (Month, Day,		28b. TIME INJU		28c. INJI WO 1 Y	RK?	NO NO	28d. DESCRIBE HOW INJURY OCCURED					
	3 Suicide 6 Could not be datermined	28s. PLACE OF II building, atc	NJURY — At hon (Specify)	ne, 1erm, st	reet, facto	ory, office			281. LOCA	ATION (Street or Town, State)	and Number	or Rural Ro	ute Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my											and manner as stated	
	29b. SIGNATURE AND TITLE OF CERTIFIES					1				piece, at			The second second	
TO BE	Julie K.	Shall	201	M	D		ASQ	402	321	5992	29d, DATE	SIGNED (Worth, Day, Year) er 15, 1995	
	30. Name and address of Person WH	SHAFFI	SEN,	MO	Print)	SI	NA	5 H	100	T41.	RA	UTU	DE MARIAN	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: II Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1. PECEDENT'S NAME (First, Middle, Leap	BOLL MA	ARY EMMA	TAYLOR	BELL		2. DATE	OF DEATH DA	17	LYEAR 95	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	1000	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH	1910		PLACE (State or Foreign
237-20-/085 90. FACILITY NAME (If not institution, give	1 M 2 F	-71-1	85 YRS.	h. CITY. TOWN O	R LOCATION OF D	HOP! L	. 71'-	9c. COU	KAW	
MERCY HOSPITAL						CITY				/a
10e. STATE 10b. COUNT	Υ		10c. CITY, T	TOWN OR LOCATI	ION				T	10d. INSIDE CITY LIMITS?
MARYLAND	n/a		BA		ore.					1 TES 2 NO
633 N. Aisa	with	Stre	ret	101.	ZIP CODE	2		UNI		STATES
11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 IF YES, GIVE WAR	EVER IN U.S. AF YES 2 XX R OR DATES	RO	If yes, spe	ENDENT OF NISPA city Cuben, Mexico 2 XO Specia	en, Puerto I		or No—	14. RACE Black Specif	- American Indian, White, etc.
15. DECEDENT'S EDI (Specify only highest grad	e completed)	(6		UAL OCCUPATIO		16b.	KIND OF BUS	INESS/INC	OUSTRY	
Elementary/Secondary (0-12) 4 th	College (1-4 or 5+)		LABOR				CAN	F.	ACTO	RY
t7. FATNER'S NAME (First, Middle, Lest) FLOYD SIMMS					18. MOTNER'S NA	AME (First, I	TAYL			
194. INFORMANT'S NAME (Type/Print) JOE BELL		19	b. MAILING AE	N. LU	ZERNE	AVEN	UE, BA	LTIM	ORE,	MD 21224
20a. METHOD OF DISPOSITION XX Buriel 2 ☐ Cremation 3 ☐ Rer	noval from State	20b. PLACE cemetery, cn	AND DATE OF DEMANDS OF THE PROPERTY OF THE PRO	DISPOSITION (Na	-	DAT		CATION —	- 1	
4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	IMI.	AUBURI		ETERY D ADDRESS OF FA	10-2	I I BA	LTIM	UKE,	MD
10	- V									
23. PART I. Enter the diseases, (if shock, or heart failure	emplications that	caused the de	eath. Do not		C. MARCH					Approximata
23. PART I. Enter the diseases, or shock, or heart failure immediate cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	s. DUE TO (C	caused the die on aech line OR AS A CONSE OR AS A CONSE	EQUENCE OF):							Approximata interval Batwee
shock, or heart failure IMMEDIATE CAUSE (Finel disesse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	b. DUE TO (C) c. DUE TO (C) d.	OR AS A CONSE	EQUENCE OF): COURNE OF): COURNE OF):	enter the modern the underlying	and a of dying, aud	oh ss carc		AUTOPSY MED?	rest,	
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na Daniel Andrews

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four the death. Face it may be mained by the hospital or attending physician and comment of the following the following physician and comments of the following the following physician and comments of the following the following physician and comments of the fol

	1 - STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIM	AE OF DEATH						
	Booker Constance Constance Amanda Booker October 19 1995 1	: 40 Pm						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HMS. 7. DATE OF BIRTH 8. BIRTHPLACE	(State or Foreign						
	212-07-0183 1 M 2 MF 90 85 YRS. MONTHS DAYS HOURS MIN. Nov. 17, 1904 Virgin	nia						
-	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
DIRECTOR	Johns Hopkins Bayview Medical Center Baltimore N/A							
Di Di	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 110d II	NSIDE CITY						
=	Maryland Baltimore Catonsville	YES 2 NO						
A L	100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT C							
BY FUNERAL	256 G. Montrose Court 21228 U.S.A.							
l S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. FRIMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — Am 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — Am 16. RACE — Am 17. Naver Married 2 Married							
≿	1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specifig. Outer, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: White S							
		1200						
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (6. Do NOT use retired.)							
<u>_</u>	Unknown College (1-4 or 5+) Office Manager American Stores							
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme)							
BE	William Davenport Haynie Lucy Unknown							
10	19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	MI. Alan Block 7921 Stanburst Blive Tikesville, Ib 2120	8						
i i	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State	ft⊕						
	4 Donaston S Other (Specify) 10/24/95 Baltimore, MD							
	22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, In	с.						
<u></u>	8728 Liberty Road Randallstown, M	D 21133						
		Approximsta interval Between						
	IMMEDIATE CAUSE (Final	Onset and Death						
	disease or condition resulting in death) a. Sepsis I week							
		DUE TO (OR AS A CONSEQUENCE OF):						
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							
₹ I	If any, lasding to immediate cause. Enter UNDERLYING							
E	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):							
	resulting in death) LAST							
L	PADT II Other elgolificant conditions conditions and thirty to do do the base of the base	AUTOPSY FINDINGS						
- ₫		BLE PRIOR TO LETION OF CAUSE						
MEDIC/	1 □ YES 2 NO OF DEL							
		ES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
SIC	HOSPITAL: 1 VES 25 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)							
F	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED							
BY	2 Accident Investigation M t YES 2 NO							
		mber,						
COMPLETED	The CERTIFIER							
MP M	29e. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the fime, dats end place, end due to the cause(e) end manner as stated.							
8	2 MEDICAL EXAMINER: On this basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end m	anner se stated.						
296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								
2		, 1945						
1	Todd S. Cox, MP Johns Hopkins Bayview Medical Center, Baltimore, M	MD]						
		1.00						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE CCT 2 0 1995 Substitution Raylett							
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O DO	s State Dept. of Health and Mental Hygiene prior to bu	10 annual
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or attending physician.

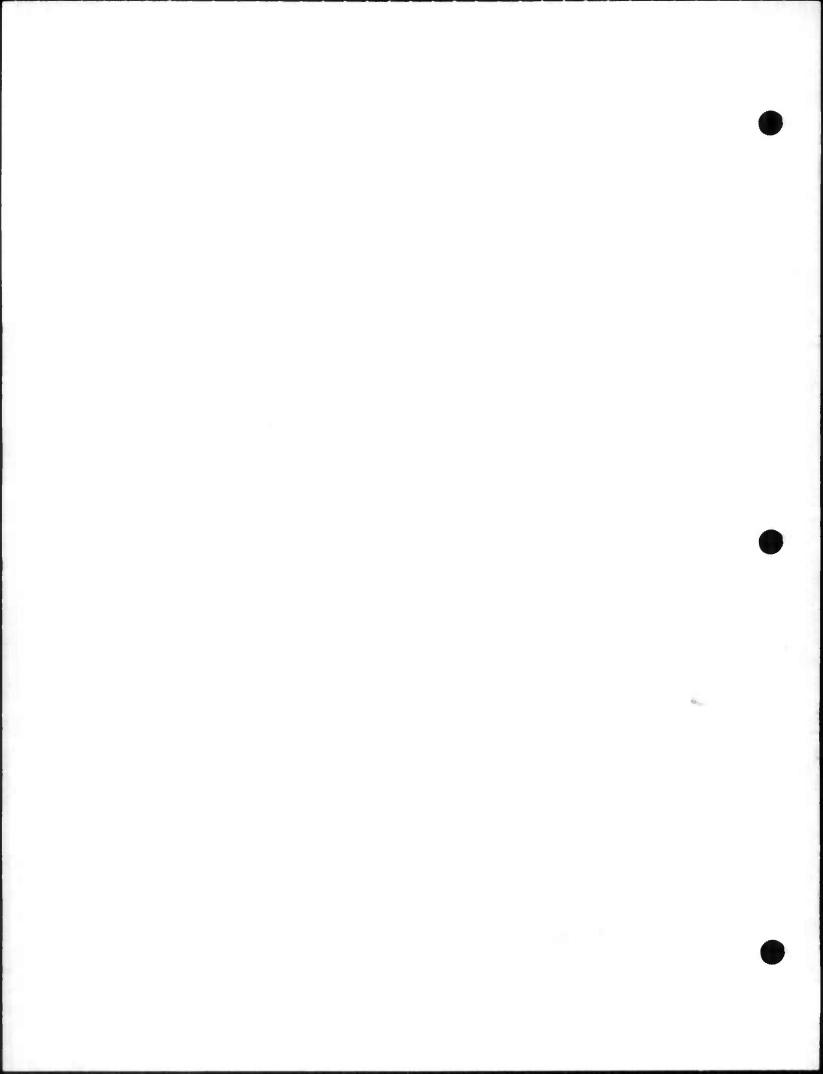
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other tranmatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE REGISTRAR	TATE OF MARYLA		TMENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	John Sharpley Bayle	Bayley			October 6	. 1995	4:00 p m	
	4. SOCIAL SECURITY NUMBER 5. S		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH	e pierri	ARI ACE (State or Femilia)
9	218-26-7571 1 (X) 9s. FACILITY NAME (If not institution, give street se	M 2 F 87	YRS.	MONTHS DAYS	HOURS MIN.	August 14,		
Œ	970 Omar Drive	na manoery		Crownsu		EATH	Anne A	
DIRECTOR	RESIDENCE OF DECEDENT			Chownso	ille		Arirle A	unaer
RE	10a. STATE 10b. COUNTY		10c. CITY	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
۵	Maryland Anne Aru	ındel	C)	rownsvil	le			1 YES 2 NO
₹ AL	10s. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	970 Omar Drive				21032		u.s	
F	11. MARITAL STATUS 1 Never Married 2 Merried	WAS DECEDENT EVER IN U FORCES? 1 YES	J.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14, RAC	E — American Indias, k, White, etc. hy: White
ВУ		IF YES, GIVE WAR OR DAT			2 X NO Speci		Spec	m White.
	15. DECEDENT'S EDUCATION	N .	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	INESS/INDIGETOY	
ET	(Specify only highest grade compliance (Specify only highest grade compliance) Elementary/Secondary (0-12) Col	leted)	(Give kind of w life. Do NOT us	vark done during mo	st of working	TOOL KIND OF BOS	MILSS/MOOS (R)	
PL	12 4+		Teache	7		School.	Sustem	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First, Middle, Maiden :		
BE (Francis Reed Bayley	1			Mae St	itt Merrymo	an	
TO B	19s. INFORMANT'S NAME (Type/Print)	on)	1			Route Number, City or Town		
F	J. Lawrence Bayley		978 On	nar Driv	e-Crowns	ville, Mary	yland	21032
	20s. METHOD OF DISPOSITION 1 Gurisi 2 Cremellos 3 Removal from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place)							
	21. SIGNATURE OF EUNERAL SERVICE LICENSE	Ronald Wa	do Dir	22. NAME AN	ID ADDRESS OF FA	MILITY		
	10000000	11/20	,	State	Anatomy	Board-655	W. Balt	imore Street
-	23 BART I Enter the disease	Nave	1			more, Mary		201-1559
	23. PART I. Entar the diseases, or complete ahock, or heart fellure. List of	only one cause on aac	ine death. Do n th line.	ot enter the mo	de of dying, aud	ch ea cardlec or reapli	ratory arrest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	DUE TO (OR AS A C	(Par a	+ + 11	Acc	ert		Onset and Death
	resulting in death) a	DUE TO (OR AS A C	ONSEGUENCE OF	9	. /			
7	_	Ciad	7 4		200	Lasar		
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF	7: 7		00 00		-i
3	cause. Enter UNDERLYING CAUSE (Disease or injury	ALC	olal	um	Chr	mi		
	that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	7):				
CERTIFICATION	resulting in death) LAST							
AL C	PART II. Other algnificant conditions con	ntributing to death but	not resulting i	n the underlying	causa given in	Part I. 24s. WAS AN	AUTOPSY 246	. WERE AUTOPSY FINDINGS
2						PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 TYES 2	ET NO	OF DEATH?
2	DID TOBACCO USE CONTRIBU	TE TO CAUSE OF	DEATH YE	S \square NO \square	UNCERTAL	ΝП		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT		- OTTOEKITAL			
Sic		SPITAL: Inpatient 2 - ER/Outpati	lent 3 DOA	OTHER:	5 Residence	6 Other (Specify)		
Ě		26s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		26d. DESCRIBE HOW IN	JURY OCCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Joan)	ING		ES 2 NO			
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, stc. (Specify,	At home, ferm, s	treet, factory, office		28f. LOCATION (Street ar City or Town, State)	nd Number or Rural F	loute Number,
COMPLETED	4 Homicide datsrmined					City of Iowin, Oldley		
P	29s, CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my knowled	ige, death occurre	d at the time, data	and place, and due	to the cause(s) and mass	ner ss ateted.	
ON	One) 2 MEDICAL EXAMINER: Os	the basis of sxamisation e	end/or investigation	n, in my opinion, d	eath occured at the	lime, data and place, end	due to the cause(s) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	101	0.		29c. LICENSE NUI	MBER	29d. DATE SIGNED	(Month, Day, Year)
TO B	Tank	1/4/	me n	\sim	022	028	► 10L	395
-	30 NAME AND ADDRESS OF PERSON WHO COM	APLETED CAUSE OF DEAT	H (ITEM 27) (Type	Print)	2.1.	Ch. O	_[]_	mn
	31, DATE FILED (MORTH-Date Year)	32. FEGISTRANS SIGNAT	LIBEO	TON (cotter	DIE!	rotton	צווגטייו
	OCT 2 0 1005	32 HEGISTRAFIS SIGNATI HILLA CURVILLED	i hardall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or the form of the following physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, remarked.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM	ENT OF	HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF DEATH		3. TIME OF DEATH
	Frederick		BROOK	S		October 1	NAY YEAR 8 1995	4:09 am
		SEX 6. AGE (In y		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Wear) 4-21-18		THPLACE (State or Foreign
OR	90. FACILITY NAME (If not institution, give street Franklin Square		96	CITY, TOWN	ROSSV11		Baltimo	DEATH re County
ב	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		404 OUTV VV	WN OR LOCA			IDGICINO.	
L DIRECTOR		timore		Roseda	le			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	2000 Wilhelm Ave			10	1. ZIP CODE 21237		USA	WHAT COUNTRY?
B≺	11. MARITAL STATUS 12 t Never Married 2 Married 3 Wildowed 4 Divorced	WAS DECEDENT EVER IN U. FORCES? 1 X YES : IF YES, GIVE WAR OR DATE WW I	2 NO	li yes, s		NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) fy:	Bie	CE — American Indian, ck, White, etc. cdy: White
ED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON 18	a. DECEDENT'S USU (Give kind of work	AL OCCUPATI	ON pat of workloa	16b, KIND OF BU	SINESS/INDUSTRY	
COMPLETED		College (1-4 or 5+)	Real Es	ired.)	of working	F	inancial	Banking
E CO	17. FATHER'S NAME (First, Middle, Last) Michael Brooks				18. MOTHER'S NA	AME (First, Middle, Maider tta Webb	Surneme)	
TO BE	190. INFORMANT'S NAME (Type/Print) Juliana Brooks		196. MAILING ADD 2000 W	PRESS (Street	and Number or Rurel AVe. Ba	Aoute Number, City or Too altimore, I	MD 21237	7
	4 Donation 5 Other (Specify)	from State 20b. PL cemeter	ACE AND DATE OF DI ry, cremetory or other p Gardens	sposition(N	ame of		altimore,	
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME A	ND ADDRESS OF FA	CILITY		HD
	Denis &	Kelly				dale Funera aco Ave.		
	23. PART i. Enter the diseases, or com ahock, or heart failure. List	plications that caused the only one cause on each	na death. Do not e n iina.	onter tha mo	de of dying, suc	ch as cardiac or resp	iratory arreat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition							Onset and Death
	resulting in death)	Pneumonia ar	d Sepsis					10 days
NOL	Sequentially list conditions, If arm, leading to immediate Systemic inflammatory Response Due to (or as a consequence of):						1 week	
FICA	Anna Patra IMPROLITIO	Congestive H	Heart Fai	lure				30 years
CERTIFICATION	resulting in death) LAST							
AL	PART II. Other aignificant conditions co	ontributing to death but	not resulting in th	a undarlyin	g cause given in	Part I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
2	Acute renal failur	e, pulmonary	hyperte	nsion	history	of to yes		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	myocardial infarct	ion, respira	tory fai	1ure				t YES 2 NO
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF I	DEATH YES	NO 5	UNCERTAI	N 🗆		
CEA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. OSPITAL:	PLACE OF DEATH (C	heck only one)				
YSI	1 VES 2 X NO 1 0	X inpatient 2 - ER/Outpatie			e 5 🗆 Residence	8 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	W	URY AT PRK? YES 2 NO	26d. DEŞCRIBE HOW	INJURY OCCURED	
	3 Suicida 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, atreet	, lectory, offic	•	28i. LOCATION (Street City or Town, Stete)	and Number or Rural	Route Number,
COMPLETED		: To the best of my knowledg						
Š	One) 2 MEDICAL EXAMINER: O	n the baels of examination an	d/or investigation, in	my opinion, o	eath occured at the	time, date end place, er	nd dua to the cause	s) end menner as stated.
BE	296. SHINAPURE AND TITLE OF CONFIER	4.0			29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)	01915		Octobe	er 18, 1995
	Aaron Hayashi, M.D.	9000 Frank		re Dri	ve, Ba	ltimore, N	4D 21237	
		Devilor Real						DHMH. 16 Ray 1/85

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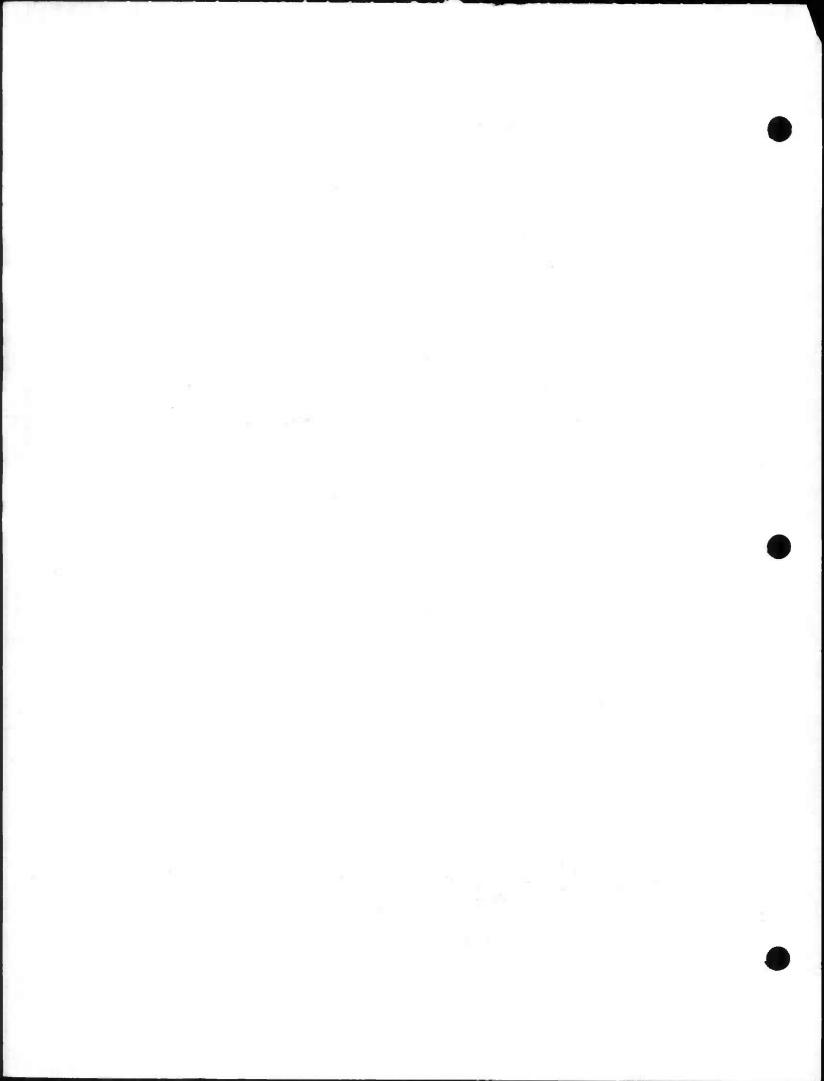
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit		
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10	5	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It from 28 is marked or from 23 shows any injury or other fraumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH BIERMAN REGINA M . 995 October 10:15A 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In vrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) 10-2-1902 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 93 DAYS HOURS 215-01-6785 1 M 2 X F VOS Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR Heritage Nursing Center Dunda1k Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY IOc. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Dunda1k 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3011 Dunleer Rd. 21222 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: BY 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George D. Crawford Anna Byers BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 2 James H. Crawford Jr. 3011 Dunleer Rd. Baltimore, Md. 21222 20a, METHOD OF DISPOSITION
1 N Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-21 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. enter the mode of dying, such as cardiac or respiratory arrest. Approximate Enfer the diseases, or complications that caused the de-ahock, or heart failure. List only one cause on each line. **Onset and Death** IMMEDIATE CAUSE (Final Central Hyperthermia disease or condition resulting in death) 1 month DUE TO (OR AS A CONSEQUENCE OF):
Congestive Heart Failure 1 month CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 10 years Essential Hypertension CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 5 years Cerebral Vascular Insufficiency PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE Pernicious Anemia 10 years 1 YES 2 X NO OF DEATH? Alzheimers Disease 1 YES 2 XNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 X Nursing Home 5 - Rasidence 8 - Other (Specify) 1 WES 2 NO 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural
2 Accident 5 Pending tovestigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, term, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER (Check only Check only 1 (X CERTIFYING PHYSICIAN: To this best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Morrith, Day, Year) 10/19/95 ATURE AND TITLE OF CHRISTER | BE (Attending Physician) armin D14160

AND ADDRESS OF PERSON WHO COMPLETED CAUGHT BEATH (ITEM 27) (Type, Print)

Brooklyn, Md. 21225

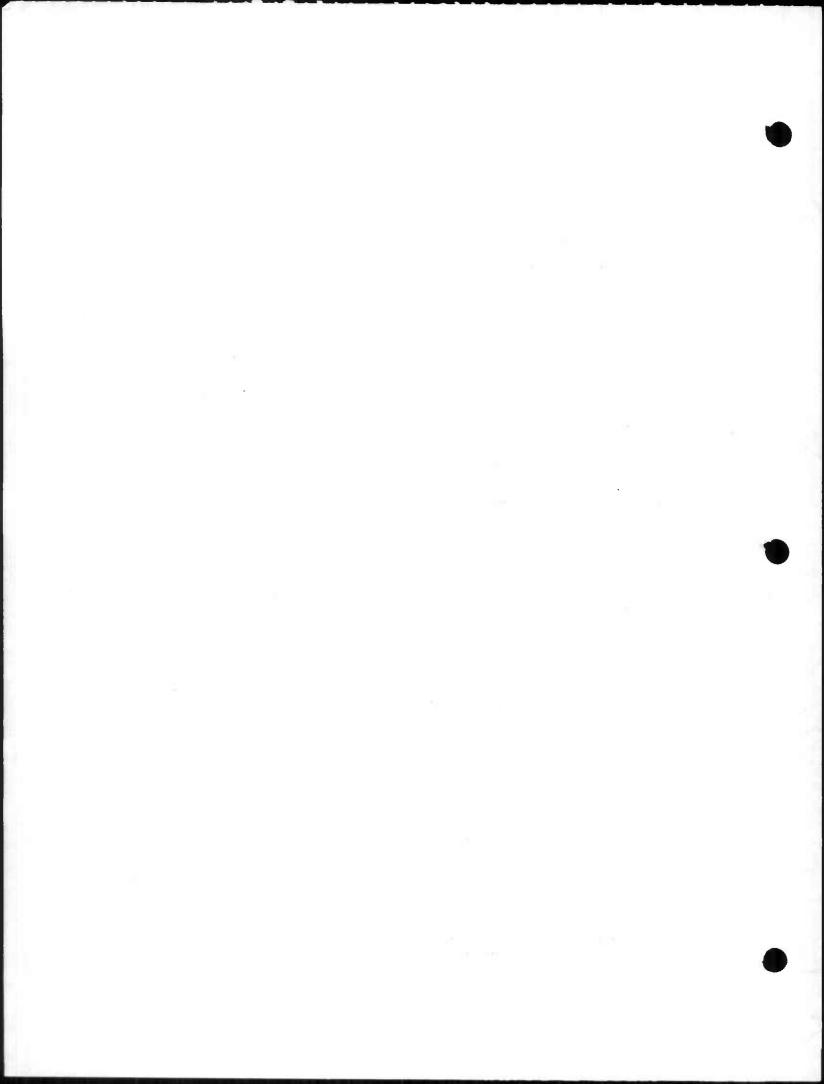


BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-ti
Ĝ	hin 24 hours afte	itely filled in by the
DIVISION OF VITAL RECORDS, P.O. BOX 68760	w requires that the death certificate be executed with	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
DIVISION OF VITAL	L OR ATTENDING PHYSICIAN: The law	DIRECTOR: After this certificate has I

he burial-transit permit. Pages 1, 2, 3 should ng physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H			YGIENE REG. NO.		
	DECEDENT'S NAME (First, Middle, Last) ROSEMARY					2. DATE OF MONTH OCTO	DAY	, 1995	3. TIME OF DEATH 8:40A M
			$\begin{array}{c ccccccccccccccccccccccccccccccccccc$			ay, Year)	8. BIRTHPLACE (State or Fore Country) MD •		
OR	ae. FACILITY NAME (If not institution, give street THE JOHNS HOPK		AL		R LOCATION OF DE		100	C. COUNTY OF	DEATH
DIRECTOR	10a. STATE 10b. COUNTY MD • N/A			Y, TOWN OR LOCAT					10d. INSIDE CITY LIMITS? 1.X YES 2 NO
	10e. STREET AND NUMBER	D		101	ZIP CODE		10	g. CITIZEN OF	WHAT COUNTRY?
BY FUNERAL	2904 ROUND ROA 11. MARITAL STATUS 1 [X] Never Merried 2	2. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 X NO	13. WAS DEC	ENDENT OF HISPAN ecity Cuben, Mexice 2X NO Specify	n, Puerto Rice		No- 14. RAI	CE — American Indian, ock, White, etc.
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12) 1 2 t h	ION npleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mose retired.)	st of working		ND OF BUSINE	SS/INDUSTRY	
	17. FATHER'S NAME (First, Middle, Lest) ROOSEVELT CART	TER			18. MOTHER'S NA ALMA	ME (First, Mide MCEI		neme)	
TO BE	190. INFORMANT'S NAME (Type/Print) ZOLLIE FORD			ROUND				tate, Zip Code)	25
	20e. METHOD OF DISPOSITION 1	ON 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place)					Town, State		
	21. SIGNATURE OF FUNERAL BUT LICENSES 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217							1217	
NC	23. PART I. Enter the diseases, or conshock, or heart feiture. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Breast DUE TO (OR AS	Can ca Consequence (1	da of dying, suc	h sa cardia	c or reapirat	ory arrest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list obnditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PHYSICIAN: MEDICAL (PERFORMED? 1 YES 2 NO CO					No. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
CIAN	DID TOBACCO USE CONTRII	OSPITAL:		ATH (Check only one)] UNCERTAI	иП			
PHYSIC	1 VES 2 NO 1	inpetient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year)	28b. TI	ME OF 28c. IN.	IURY AT DRK?			JRY OCCURED	
ВУ	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm,		YES 2 NO		ON (Street end Town, Stete)	Number or Run	of Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 29 MEDICAL EXAMINER:	AN: To the best of my know							e(s) end menner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	m HD		29c. LICENSE NUMBER DY7642				29d. DATE SIGNED (Month, Day, Year) 10-19-9	
F	30. NAME AND ADDRESS OF PERSON WHO HILLARY HAHM	and the same of th		wolfe Wolfe	ST	BAL	1740	NE P	10
	OCT 2 1 1995 Jaly	32. REGISTRAR'S SIG	LA						



OCT 2 0 1995

Jal 32 REGISTRAR'S SONATURE

Ιt	em# 1.G-film per F.H 10/20/95						
	1 - STATE STATE OF MARYLAND / DE CERT	PARTMENT OF H		MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) Patricus ANN	Coburn		2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birth	hday) IF UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	7	11	PLACE (State or Foreign
	2 332 6 8 9 1 0 M 2 FF 60 Y. Se. FACILITY NAME (If not institution, give street and number)	RS.	R LOCATION OF DE	Sept.14,19			land
TOR	Good Samaritan Hospital	Baltimor		AIN		I/A	EATN
DIRECTOR	10e. STATE 10b. COUNTY 10e	c. city, town on Locat Baltimore	ION				10d, INSIDE CITY LIMITS? 1 X YES 2 NO
3AL	10e. STREET AND NUMBER	1	ZIP CODE		tog. CITI	ZEN OF Y	VHAT COUNTRY?
FUNERAL	5735 Cedonia Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED		21.206	IC ORIGIN? (Specify Yea	U.S		American Indian.
ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced 1 YES, GIVE WAR OR DATES	If yee, spi	city Cuben, Mexicar 2 XNO Specify.	n, Puerto Ricen, etc.)	or No-	Black Speci	, White, etc.
COMPLETED	(Specify only highest grade completed) (Give kii	ENT'S USUAL OCCUPATION IN THE PROPERTY OF WORK done during most	N st of working	16b. KIND OF BUS	SINESS/IND	USTRY	
PLE	Elementary/Secondary (0-12) College (1-4 or 5+)	not use retired.) h Board Ope	rator	Machine	arv C	່າ ຕາກາລ	my
MO	17. FATHER'S NAME (First, Middle, Last)	i Doard Ope		ME (First, Middle, Maiden	_	Anipo	шту
BE 0	Harry A. Weilbrenner			izabeth Ke			
10	Chwighing D. Dorma (D. 14.)	AILING AODRESS (Street a			,	, , , ,	
	20e. METHOD OF DISPOSITION 20b. PLACE AND I	3 Juneway; DATE OF DISPOSITION (Na	me of	DATE 20c. LO	CATION -		wn, State
	tXI Burlel 2 A Cremation 3 Remove from tate cemetery, crematory or other place Gardens of Faith Cem. 10/23/95 Baltimore, Maryland						
	22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home						
	fuen in fine			ne, Baltin			
	23. PART I. Emer the diseases, or complications that caused the death. anock, or heart failure. List only one cause on each line.	Do not enter the mo	de ot dying, aucr	i de cardiac or respi	ratory an	reet,	Approximate interval Batween Onast and Death
	disease or condition resulting in death) Bould is hemo-						4 durs
	DUE TO (OR AS A CONSEQUENCE OF):						
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 4 7					4 yrs	
CAT	If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury						
CERTIFICATION	thet initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST						
CE	d						1
CAL	PART II. Other significant conditions contributing to death but not result	ting in the underlying	ceuse given in	PERFOR	MED?	24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	Penipheral Variables of	view		t _ YES 2	Ø NO		OF DEATH?
 S	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A						
PHYSICIAN:	EXAMINER? HOSPITAL:	OTHER:					
HYS	1 ☐ YES 2 ☐ NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ C 27. MANNER OF DEATN 26e. DATE OF INJURY 28		e 5 Reeldence	8 Other (Specify) 26d, DESCRIBE NOW II	NJURY OC	CURED	
ВУ Р	t Natural 5 Pending (Month, Day, Year)	INJURY WO	RK? (ES 2 NO				
	2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, building, etc. (Specify)	term, street, fectory, offic		28f. LOCATION (Street a City or Town, State)		r or Rural I	Ploute Number,
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death of m						a) end menner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUN				(Month, Day, Year)
TO BE	Ali Mousse, M.D.		Po 93		▶ /10	OCT.	20, 1935
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27	(Type, Print) Raven	Bluel.	Rolling	,	MI	21239

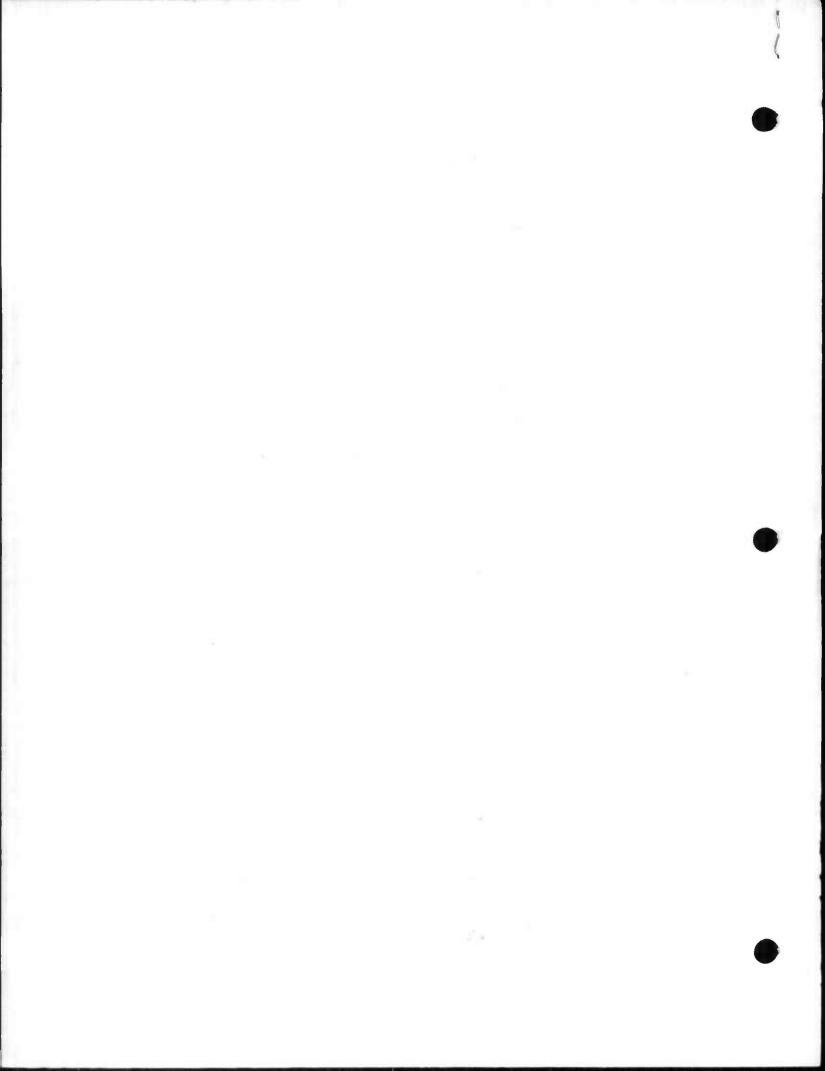
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BALTIMORE, MARYLAND 21215	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend	Company of the same of the sam
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with the flow and the death. Page 6 may be retained by the hispitation.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM			MENTAL HYGI					
	1. DECEDENT'S HAME (First, Middle, Last)				52,711	2. DATE OF DEATH	1		3. TIME OF DEATH		
	MURIEL MARY	CARROLL				OCTOBER		YEAR	8:05	DM	
			6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIR								
	119-07-7934 Ba. FACILITY HAME (If not institution, give stre	1 M 2 F 74	X /4								
TOR	THE JOHNS HOPKINS				ORE CITY			n/a			
THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a FRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION RUXTON Maryland Baltimore Ruxton											
FUNERAL	100. STREET AND NUMBER 2020 A. Skyline F	Road		101	2120	4	10g. CITIZE		1 VES 2 N		
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 S IF YES, GIVE WAR OR DATES		If yes, sp	ENDENT OF HISPAI solfy Cuban, Mexica 2 XNO Specifi	NIC ORIGIN? (Specify in, Puerto Rican, atc.) y:	Yes or No.— 14	4. RACE Black Specif	- American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	empleted)	DECEDENT'S USUA (Give kind of work of the Do NOT use retir	lone durina mo	ON st of working	16b. KIND OF	BUSIHESS/INDUS	TRY	WILCE		
APL	12	Med	dical Se	cretai	сy		Medicin	e			
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Mail	den Surname)				
BE (John Joseph Wall,	Jr.			France	s Kelly	,				
10	19a. IHFORMANT'S NAME (Type/Print) Mrs. Kathleen C.	Pinney 2				Route Number, City or TOWSON, M.			.204		
	20a. METHOO OF DISPOSITION 1	al from State cemetery, c	E AND DATE OF DIS	acel			LOCATION — CR				
	21. SIGNATURE OF FUNERAL SERVICE ALCES	dex / /	ob serv		orp. 10/		Towson	ма	ryland	-	
	* Michael &	auck.		Ruck !	Towson F	uneral Ho	me, Inc	. 1	.050 York	Rd	
	23. PART I. Enter the diseases or con ahock, or heart failure. Lis	mplications that caused the cast only one cause on each lin	deeth. Do not a	nter tha mo	de of dylng, suc	h aa cardlac or re	apiratory arrea	it,	Approximate		
	IMMEDIATE CAUSE (Final			.1					Onset and I		
	disease or condition resulting in death)	Subavachi	noid	Hemo	rrhage	_			16 hour	V5	
	disease or condition										
ON	Sequentially list conditions, b.	Giaut Aue	UNYSW						Syear	15	
TA:	if any, leading to immediate cause. Enter UNDERLYING	DOE TO TON AS A CONS	EUGENCE OF);								
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	EQUENCE OF):								
CERTIFICATION	reaulting in death) LAST										
	PART II. Other eignificent conditions	contributing to death but not	moulting in the			0.41					
₹ E	The state of the s	contributing to deeth but not	resulting in the	underlying	j ceuse given in		AH AUTOPSY FORMED?	1	WERE AUTOPSY FIND AVAILABLE PRIOR TO		
MEDIC						1 [] YES	2/35/10		OF DEATH?	JOE.	
Σ	DID TOBACCO USE CONTRI	RUITE TO CAUSE OF DE	ATLI VEC F	I NO TO	L LINICEDTAIN				1 YES 2 HO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		ACE OF DEATH (C)		UNCERIAII	ן טיי					
SIC		IOSPITAL:		HER:	s 5 □ Residence	8 Other (Specify)					
¥	27. MAHHER OF OEATH	28a. DATE OF IHJURY (Month, Day, Year)	28b. TIME OF	28c. IHJI	JRY AT	28d. DESCRIBE HO	W IHJURY OCCUI	RED		\dashv	
ВУ	1 Hetural 5 Pending 2 Accident Investigation	(WORLD, Day, Tear)	IHJURY		RK7 ES 2 HO						
	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At It building, etc. (Specify)	nome, farm, atreet,	factory, office		281. LOCATIOH (Stre City or Town, Str	et and Number or ate)	Rural Ro	oute Number,		
'n	29a. CERTIFIER CERTIFYINO PHYSICIA	AH: To the best of my knowledge, o	Seath occurred at a	he time dete	and place, and due	to the seven(s) and s					
COMPLET		On the basis of examination and/or							and manner as state	ed.	
	250. AND THE CHE CHETTERIN	1-11	1		29c. LICEHSE NUN				(Month, Day, Year)		
H	Muchael Celi	Wellist W	(1)		14nm	41	► //)	- /	8.95		
2	30. HAME AHD ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEATH (IT	EM 27) (Type, Print)		0 100	11	10	- (0 10		
	Michael A William 31, DATE FILED (MORTH), DRY, MARY	US. AD 6001	1. Wolfe	Stree	et More	18.140	altimo	e	21287	7	
	OCT 2 01995	32 REGISTRAR'S SIGNATURA	16								



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DIVISION OF VITAL RECORDS, F	A
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ND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in the first may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the Silver Should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

5

3 Suicide

4 Homicide

BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 - STATE REGISTRAR		STATE OF M	MARYLAN	D / DEPA					MENTAL	HYGIEN REG. NO.				
1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF DEATH		YEAR	3. TI	ME OF DEATH
GEORGE LE	E CURN	OLES								ber 1			1	:00 P. M
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yr	s. last birthday		DER 1 YEAR	IF UNDER		7. DATE OF BIRTH B. BIRTHPL					E (State or Foreign
218-26-4216		1 🔀 M 2 🗌 F		63 YRS.	MONT	HS DAYS	HOURS	MIN.	Nov.	15, 1	931	Mar	ÿla	ind
9e. FACILITY NAME (If not in	stitution, give s	treet end number)			9b. 0	SITY, TOWN	OR LOCATIO	ON OF D	EATH		9c. COL	INTY OF E	DEATH	
Stella Mari						Tows	son					Balt	imc	re
RESIDENCE OF DEC												-		
10e. STATE	10b. COUNTY			10c. C		VN OR LOCA							10d.	INSIDE CITY LIMITS?
Maryland					1	Baltin								YES 2 NO
10e. STREET AND NUMBER						10	t. ZIP CODE							COUNTRY?
4110 Fordleigh Road 21215 United States														
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indien, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — American Indien, Black, White, etc.														
Never Married 2 Merried IF YES GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:														
3 Widowed 4 Divo	roed		Kor	ea									V	Vhite
	EDENT'S EDU		16:	Give kind o	S USUA	L OCCUPATE	ON ost of working	10	18b.	KIND OF BU	SINESS/IN	DUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5 +) Iffe. Do NOT use retired.)														
4 years Teacher & Musician Self-Employed														
17. FATHER'S NAME (First, M	liddle, Last)						18. MOTI			liddle, Maiden				
		C	urnole	S				Ma	ary W	esterf	ielo	1		
190, INFORMANT'S NAME (Type/Print)									er, City or Tow				6.0
Mr. Blaine		t		200	Ε.	Lexi	ngton	Sti	reet	Baltin	nore	MD	21	1202
20a. METHOD OF DISPOSIT 1 ☐ Buriel 2 🙀 Crematic 4 ☐ Donation 5 ☐ Other	n 3 🗆 Rem	oval from State		CE AND DAT				ice	10/			ead,		aryland
21. SIGNATURE OF FUNERA		CENSEE	0		,	22. NAME A	ND ADDRE	SS OF F	CILITY	al Din			Tn	
· Jan	mel	BC	ove	dy										D 21133
23. PART L Enter the d	iseeses, or e	complications the	t council in	death. Do	not er	nter the mo	ode of dy	Ing, suc	ch as card	llac or resp	iratory a	rrest,		Approximate Interval Between
IMMEDIATE CAUSE (FI		Ciet only one ce												Onset and Death
disease or condition	→	RECT	ALC	AR	SIL	20 m	A							6 mos
resulting in death)	,	DUE TO	(DR AS A CO											,
Sequentially list condit if any, leading to imme	diete	DUE TO	(OR AS A CO	NSEDUENCE	OF):									04, 5
cause, Enter UNDERLY CAUSE (Disease or Inju		c			_			_						
that initiated eventa reaulting in death) LAS		OUE TO	(OR AS A CO	NSEDUENCE	DF):								i	
readiting in death, EAC		d											-	
PART II. Other eignifica	int condition	ns contributing to	deeth but	not resulting	a In the	e underivin	a ceuse	alven in	Part I.	24a. WAS AN	AUTOPSY	24	b. WER	E AUTOPSY FINDINGS
PROSTA	78-	CANT	GR	210	25.	-			- 1	PERFD				LABLE PRIOR TO
12001	, ,		V	24	-00				— [1 YES	NHO		OF D	DEATH?
DID TOTAL COLUMN		201122 20 21	1105.05	¥	/F.C. F	7 110 100	M	nen=+-					1 🗌	YES 2 NO
DID TOBACCO U		KIBUTE TO CA						CERTAI	ΝЦ					
25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:	26.	PLACE OF DE		HER:)				-			
1 TES 2 NO		1 Inpetient 2	ER/Outpetle	nt 3 DOA			ne 5 🗆 R	esidence	6 12 Othe	r (Specify) I	IOSD1	CE		

26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 1 Natural
2 Accident

28d. DESCRIBE HOW INJURY OCCURED

26c. INJURY AT WORK? 2 ND 26e. PLACE OF INJURY - At he building, etc. (Specify)

29e. CERTIFIER (Check only one)

296. SIGNATURE AND TITLE OF CERTIFIER

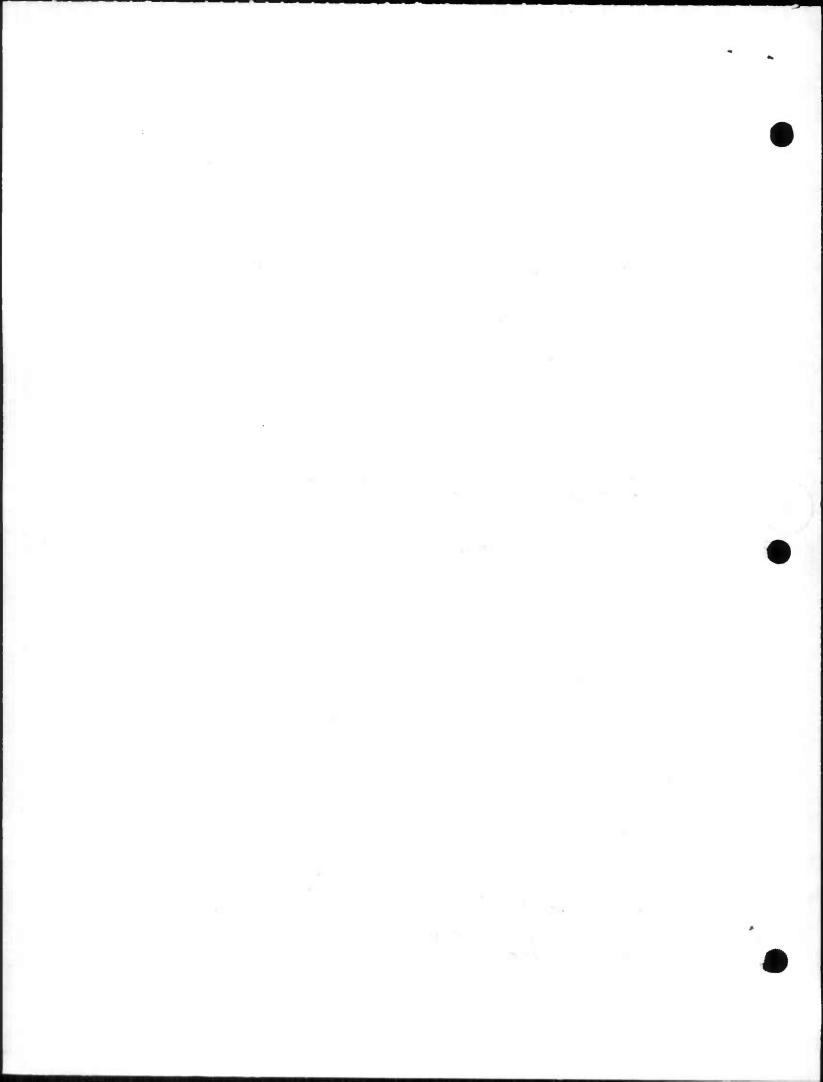
D 256

29d. DATE SIGNEO (Month, Day,

DR. KENDALL FAULKNER TOWSON, MD 21204

OCT 2 0 1995





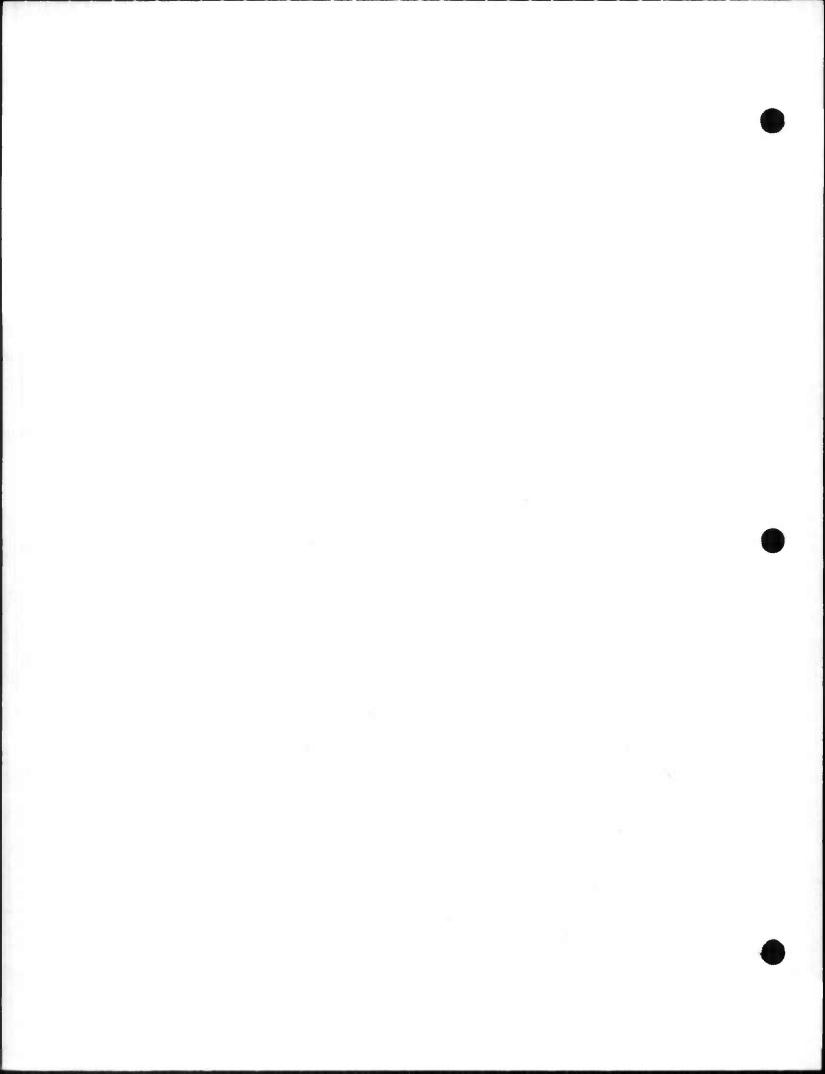
BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

DALLIMORE, MARTLAN	nours after death. Page 6 may be retained by the hos	ed in by the funeral director, page 5 should be detach or removal.	medical examiner must be notified at once.
Constitution of the Country, F.O. Box 651 00	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a roous after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at ence.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CE	RHE	CATE OF	DEATH	REG. N	0.		
	1. DECEOENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3.	TIME OF DEATH
1	Richard Chism						MONTH	DAY	YEAR	10 45 "
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (in yrs. last	trace i			October 7			12:45 p M
	The second secon	1 X M 2 F	AGE (IN yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign
	217-24-0159		0.5	YRS.			Sept. 14.	1930		
1	9a. FACILITY NAME (If not institution, give					OR LOCATION OF E			NTY OF DEAT	
DIRECTOR	1622 Clarkson St	reet			Balt	imore				
I K	RESIDENCE OF DECEDENT									
I	10e. STATE 10b. COUNT	TY		10c. CITY,	TOWN OR LOC	TION			10	d. INSIDE CITY
1 5	Maryland			Bal	timore					LIMITS?
										X YES 2 NO
M	10e. STREET AND NUMBER					H. ZIP CODE			ZEN OF WHA	IT COUNTRY?
FUNERAL	1622 Clarkson St	reet				212:	30	u	.S.A.	
15	11. MARITAL STATUS	12. WAS DECEDENT EV	/ER IN U.S. ARM	IEO	13. WAS DE	CENGENT OF HISPA	NIC ORIGIN? (Specify	fon or No	14 PACE	American Indian
	1 Never Married 2 Married	12. WAS DECEDENT EX	YES 2 NO		If yea, a	pecify Cuban, Maxic	en, Puerto Rican, etc.)	- 0.1 1.0		American Indian, fhite, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 🗆 YE	S 2 NO Spec	lly:		Specify:	White
H	15. DECEDENT'S EDU (Specify only highest grad		16a. DEC	EOENT'S U	SUAL OCCUPAT ork done during in retired.)	ION lost of working	16b. KIND OF E	USINESS/INI	DUSTRY	
i iii	Elementary/Secondary (0-12)	College (1-4 or 5+)					Pompeia	n Oli	ve Oil	2 Company
. 프	12	Z	Comp	outer	Progra	ammer				0
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					18 MOTHER'S N	AME (First, Middle, Maid	on Company		
	Dausie Chism					Amolia	Mozigamda	in surname)		
BE										
2		wife)	19b.	MAILING /	DDRESS (Street	and Number or Rural	Route Number, City or 1	own, State, Zij	Code)	
F	Christine Chism		10	322 C	larkso	i Street.	-Baltimore	, Mar	yland	21230
	20a. METNOD OF DISPOSITION		20h PLACE AL	ID DATE OF	OISPOSITION //	lame of	OATE 20c.	OCATION	City or Town,	24-4-
	1 🗆 Burial 2 🗆 Cremation 3 🗆 Ren	noval from Stata	cemetery, crem			ame or	OATE 20C.	OCATION —	City or lown,	State
	4 Donation 6 Other (Specify)									
	21. SIGNAPURE ON FUNERAL SERVICE LI	CENSEE Ronald	Wade,	Dir.	22. NAME	NO ADDRESS OF F	ACILITY DOWN & CE	E (a) 1	2 0 + :	ore Street
	Non weel 1	Mhin								ore screet
<u></u>	111/100///	nuce		_	Rm.BC	26-Balti	more, Mar	yland	2120	1-1559
	23. PART I. Enter the diseases, or	complications that ca	used the dee	th. Do no	t enter the m	ode of dying, suc	ch as cardiac or res	piretory an	rest,	Approximate
	shock, or heart failure.	List only one cause	on each line.							Interval Between
	IMMEDIATE CAUSE (Final disease or condition	01		1	1.	D	1.			Onset and Death
	resulting in death)	· Chron	7166	1057	nictive	Julmo	mary dise	ase		
		OUE TO (OR	AS A CONSEQU	JENCE OF)						
z		h								
9	Sequentially list conditions,	DUE TO (OR	AS A CONSEQU	JENCE OF)						
14	if any, leading to immediate cause. Enter UNDERLYING									İ
CERTIFICATION	CAUSE (Disease or Injury	C. DUE TO COD	AS A CONSEQU	ENOS OS						
	thet initiated events resulting in death) LAST	DOE TO (OR	AS A CONSEGR	ENCE OF						
1 15	Tooling in death, Exci	d								
	DART II Oshor desidence and del	Control and the second								
EDICAL	PART II. Other aignificant condition	ne contributing to dee	ith but not re	nulting in	the underlying	g cause given in	Part I. 24a. WAS /	N AUTOPSY ORMED?		RE AUTOPSY FINOINGS
9	Alcoholism						1 _ YES		co	MPLETION OF CAUSE
							' ' 'E3	Z UM NO	OF	DEATH?
Σ	212 - 22 - 12 - 22 - 12 - 22 - 22 - 22								1 [YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	H YES	X NO L	UNCERTAI	N 🗆			
15	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEATN	(Check only one)				
1 %	1 TES 2 NO	HOSPITAL:	(Outpetlant 2 [OTHER:	- 1/				
=	27. MANNER OF DEATH						6 Other (Specify)			
古	_	(Month, Day, Y		26b. TIME INJU		JURY AT ORK?	284. OESCRIBE HOV	INJURY OC	CURED	
B	1 X Natural 5 Pending 2 Accident Investigation				M 1 🗆	YES 2 NO	1			
	3 Suicide 8 Could not be	26a. PLACE OF IN.	JURY — Al hom	e, farm, str	eet, factory, offi	a	26f. LOCATION (Street	t and Number	or Rural Route	Number,
	4 Nomicide determined	building, etc.	(Specify)				City or Town, Sta	(a)		
<u></u>										
COMPLET	29e. CERTIFIER (Check only 1 🔀 CERTIFYING PNYS	ICIAN: To the beat of my	knowledge, deet	h occurred	at the time, dat	and place, and du	o to the cause(a) end m	anner as stat	ed.	
8		ER: On the basis of exami								d manner se stated.
1×1									(-) an	
	29b. SIGNATURE AND TITLE OF CERTIFIE	11				29c. LICENSE NU	MBER	29d. DAT	E SIGNED (MO	onth, Day, Year)
	01.0	11.0				D3530	.2		0/12/	
BE	Sharch	ellino Aco	15/AC					, ,	0 121	95
	Sharsh	O COMPLETED CAUSE O	SAC F DEATH (ITEM	27) (Type, F	rint)	D222		1, 1	0 13	95
BE	Sharsh	O COMPLETED CAUSE O						1 2	0[13]	9.5
BE	Sharsh	ello Aca 10 COMPLETED CAUSE O 11 MD BVA			Greens		ltimore, M	d. 21	201	95
B	Sharsh	OCOMPLETED CAUSE O						d. 21	201	95



BALTIMORE, MARYLAND 21215-0020

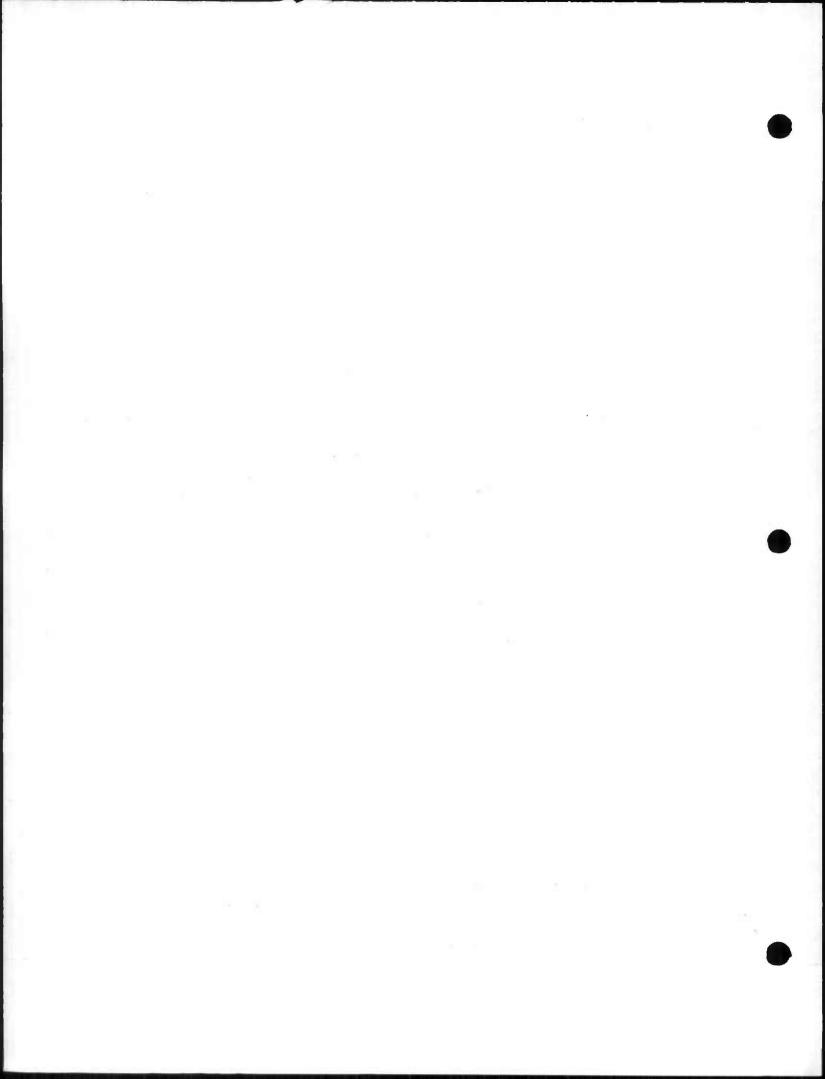
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		ARTMEN				MENTA	L HYGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH		3	. TIME OF DEATH
	LINDA C.	CROWE						Octo			995	11:30A M
	77 - 25 1/3 20 -	S. SEX 6. AGE	(In yrs. lest birthd		R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		. BIRTHPL	ACE (State or Foreign
	218-01-6265	□ M 2 □XF	76 YRS	MONTHS	DAYS	HOURS	MIN.		n, Day, Year) 4 — 1919	9 1	Country)	sylvania
	9s. FACILITY NAME (If not institution, give street	t and number)		9b. CIT	Y, TOWN (R LOCATIO	ON OF DE				Y OF DEA	
8	Heritage Nursi	ng Center		D	unda	alk				Ba1	Ltim	ore
티ս	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		100	10c. CITY, TOWN OR LOCATION							L	
DIRECTOR	Maryland Balt:	imore	100.									0d. INSIDE CITY LIMITS?
4	10e. STREET AND NUMBER	IMOTE		Dundalk 100. ZIP CODE						10a CITIZI		YES 2 NO
NA	3005 Dundalk Av	ve.			"		222				JSA	AI COONTAIT
BY FUNERAL		2. WAS DECEDENT EVER I	N U.S.ARMED	13.	WAS DEC			IIC ORIGIN	17 (Specify Yes			- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO		It yes, sp	ecify Cubs	n, Maxica	n, Puarto	Rican, atc.)		Black, V Specify:	White, atc.
	3 Widowed 4 Divorced						apouny				opoony.	White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade col	*ION mpleted)	16a. DECEDEN (Give kind	of work done	during mo		ng	16b	KIND OF BUS	INESS/INDU	STRY	
ا لا		College (1-4 or 5 +)		T use retired.)				١.				
\$	1. 2 17. FATHER'S NAME (First, Middle, Lest)		Brok	er					insura			
	Tito Greco							Fre	Middle, Malden	Surname)		
8	19a. INFORMANT'S NAME (Type/Print)		10h MAII	INC ADDRES	10 (Street o				ber, City or Yown	Contract Time Co	2-4-1	
임	Thomas G. Crowe	9		1 Du					timor			21222
	20A, METHOD OF DISPOSITION	20	b. PLACE AND DA		_			DAT		CATION — CI		
	1 X Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State Car	St. St	or other piece)		m 1	1				
	21. SIGNATURE OF FUNERAL SERVICE LICEN		30. 50	22	NAME A	D ADDRE	SS OF FA	CILITY				
	Cottlemus C.	It Com	00.									ındalk
	23. PART I. Enter the disease, or cor	mplications that cause	d the death I	o not ente	/ I I C	SO.	I Ter	rs P	oint	Ra.	212	Approximate
	shock, or heer fellure. Lie	t only one ceuse on e	each ilne	70 1700 01110		as or ay	rig, auci	II do Car	siac or respi	atory sire	Bt,	interval Between Onset and Death
	IMMEDIATE CAUSE (Finel disease or condition	Left Th	alamic	Hemor	rhac	e						3 weeks
	resulting in death) a	DUE TO (OR AS	A CONSEQUENC	E OF):								
z		Parkinson's	Disea	ase								4 years
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS										
2	CAUSE (Disease or Injury	Coronar			ease							3 years
ËΙ	that initiated eventa reaulting in deeth) LAST	·		,								2 170250
CERTIFICATION	d,	Alzheimer'	s pisea	ase								2 years
	PART II. Other algnificent conditions	contributing to deeth	but not reculti	ng In the u	nderlyin	g ceuse i	given in	Part i.	24a. WAS AN PERFOR			VERE AUTOPSY FINDINGS
읽									1 TYES 2		0	OMPLETION OF CAUSE OF DEATH?
W												□ YES 2 XNO
SICIAN: MEDICAL	DID TOBACCO USE CONTRI	BUTE TO CAUSE O] UNC	ERTAI	N 🎦				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF I	QTHE	-							
YS	1 YES 2 X NO 1	Inpetient 2 - ER/Out		A 4,X) Nu	rsing Hon	10 5 □ Ra	sidence	-	(-)//			
РНУ	27. MANNER OF DEATH 1 X Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF INJURY	WC	URY AT	7.110	28d. DE	SCRIBE HOW II	NJURY OCCI	JRED	
BY	2 Accident Investigation	28s. PLACE OF INJUR	Y — At home ta	rm street ter		YES 2	J NO	281 1.00	CATION (Street 8	and Number o	or Primal Plan	sto Mambae
윤	3 Suicida 6 Could not be 4 Homicide dstarmined	building, atc. (Spe	ocify)	,	otory, orme				or Town, State)	ino Number c	THOMAS PROD	ne rrantoei,
COMPLETE	29a. CERTIFIER 1 X CERTIFYING PHYSICIA	AN. To the head of the least	4.44									
M	(Check only one) 2 MEDICAL EXAMINER:											and menney as eleted
8	29b, SHAMATIPE AND TITLE OF CERTIER &											
B	darke in	Att	ending	Phys:	icia	L)	D141	160			10/19	Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	W13									-,	,
	Harjit Singh N		O A Ri		Hwy	7.	Bro	okly	n, Mo	1. 21	.225	
	31. DATE FICED (Month, Day, Year)	32. REGISTRAR'S SIG										
	OCT 2 0 1995 Jalia	Buderhard	K									



retained by the hospital or attending physician. 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 2 Jay.

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notified

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must

MEDICAL

PHYSICIAN:

BY

COMPLETED

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Pages 1, 2, 3 should

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 m TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal, IMPORTANT: If Hem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner mus	9	ector,		MUS
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it of THE FUNERAL DIRECTOR: after this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical experiences.	death. Pag	funeral dir		xaminer
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completel be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, crems IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event,	1 54	y fille	tion.	the
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic	ed within	ompietel	I, crema	event,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other trau	execute	and co	to buria	matic
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending bit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other	te be	ysiciar	prior	trau
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attentoe filed within 72 hours after death with the State Dept, of Health and Mental HIMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or	certifica	ding ph	lygiene	r other
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept, of Health and M IMPORTANT: If item 28 is marked, or item 23 shows any Inju	death	aften	ental	IT, 0
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL DIRECTOR: After this certificate has been signed be filed within 72 hours after death with the State Dept, of Health at IMPORTANT: If Item 28 is marked, or Item 23 shows any	the	y the	M Du	重
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law require TO THE FUNEPAL DIRECTOR: After this certificate has been sig be filed within 72 hours after death with the State Dept, of Hee IMPORTANT: If item 28 is marked, or item 23 shows	s thai	ned t	ith a	any
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If item 28 is marked, or item 23:	require	een sig	of Hea	shows
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The TO THE FUNERAL DIRECTOR: After this certificate he filed within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Item	I SW	as b	Dept.	23
TO THE MOSPITAL OR ATTENDING PHYSICIA TO THE FUNERAL DIRECTOR: After this certif be filed within 72 hours after death with the IMPORTANT: If Nem 28 is marked, or	N: The	icate h	State	Hem
TO THE HOSPITAL OR ATTENDING PHYS TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with IMPORTANT: If Item 28 is marked	SICIA	certif	the	. 0
TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after deal IMPORTANT: If Item 28 is m	S PHYS	r this	th with	arked
TO THE HOSPITAL OR ATTEN TO THE FUNERAL DIRECTOR be filed within 72 hours after IMPORTANT: If Item 28 i	DIN	Afte	deal	E
TO THE HOSPITAL OR A TO THE FUNERAL DIRECT De filed within 72 hours IMPORTANT: If Item	TEN	JOR.	after	28
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	OR A	DIREC	HOURS	tem
TO THE HOSP TO THE FUNE De filed within	TAL	RAL	2	=
THE F TO THE F De filed v	HOSP	UNE	vithin	ANT
	TO THE !	TO THE F	be filed w	IMPORT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH ANNA BERNIECE DOWNING OCT. 17 1995 10;45a 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTN IF UNDER 1 YEAR BIRTNPLACE (State or Foreign Country) IF UNDER 24 HRS. (Month, Day, Year) 12-24-04 1 - M 25 F 90 YRS 215-32-2106 VIRGINIA 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1823 W. FAYETTE STREET BALTIMORE N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO MD. N/A BALTIMORE FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 1823 W. FAYETTE STREET 21223 USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, Whife, etc. 1 Never Married 2 Merried Specify: BY 3 XWidowed 4 Divorced BLACK ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 8th DOMESTIC SELF EMPLOYED 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) LULA DOWNING MATTIE DOWNING BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 1823 W. FAYETTE STREET, BALTO. MD. CLAUDIA K. MCKEE 21223 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE LOUDEN PARK CEMETERY 10-23-95 BALTO. MD. 21. SIGNATURE OF FUNERAL MERCURE LICENSES 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H 638 N. GILMOR STREET 21217 23. PART I. Enter the disease, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition_ resulting in death) CERTIFICATION Sequentially list conditions,

if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. entlin Con

24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 TO NO

26d. DESCRIBE NOW INJURY OCCURED

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN

26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
4 | Nursing Name 5 | Residence 8 | Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH

28e. DATE OF INJURY (Month, Day, Year) 5 Pending

pression

6 Could not be

determined

26b. TIME OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, etc. (Specify)

vsus

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER

(Chack only

1 [PCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) end manner se stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

60 ADDRESS OF PERSON_WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 630355

29d. DATE SIGNED (Mo

COSITA

801 WASHINGTON

31. DATE FILED (Month,

1 Natural

3 Sulcide

4 Nomicide

Accident

DNMN-16 Ray 1/89

.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		3. TIME OF DEATN		
-	KAZYS DULY	S					OCTOBE	DAY	1995	7:55 A. M		
- 1	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest	State of mark	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I			HPLACE (State or Foreign		
					MONTHS DAYS	NOURS MIN.	(Month, Da	ly, Year)	Coun	try)		
	213-30-7820	1 x M 2 □ F 8	9	YRS.			MARCH	1,1906	LII	HUANIA		
	Se. FACILITY NAME (If not institution, give s	itreet and number)			9b. CITY, TOWN C	R LOCATION OF DI	EATN	9c. 0	COUNTY OF	DEATN		
E	617 CEDARWOOD LAN	F			CROW	NSVILLE			ANNE	ARUNDEL		
5	RESIDENCE OF DECEDENT						CROWNSVILLLE					
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY		
DIRECTOR	MARYLAND AN	NE ARUNDEL		CRO	WNSVILLE					LIMITS?		
	10e, STREET AND NUMBER	THOUDDS		Oito		ZIP CODE		1 40-	OFFITEN OF	WHAT COUNTRY?		
Z.					101			109.				
	617 CEDARWOOD LA	NE				21032		U.S.	Α.			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT ET	VER IN U.S. AR	MED	13. WAS DEC	ENDENT OF NISPAI	VIC ORIGIN? (S	pecify Yea or No	- 14. RAC	CE — American Indian, ck, White, etc.		
	1 Never Married 2 Married	IF YES, GIVE WAR		10		2 X NO Specif		n, etc.)				
BY	3 📉 Widowed 4 🔲 Divorced	0 /2/200								WHITE		
	15. DECEDENT'S EDU		16a. DE	CEDENT'S	USUAL OCCUPATIO	N	16b. Kit	ND OF BUSINESS	INDUSTRY			
E	(Specify only highest grade		(Gi	ve kind of v	work done during mo se retired.)	st of working						
٦	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 YRS					CTO	THING N	ANIITA	CTURING		
ž		4 IK5	IA	ILOR	. :				_	CIURING		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA						
BE	VINCAS DULINSKAS					MARIJA	JAKUBA	USKIUTE				
	19a, INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number,	City or Town, State	, Zip Code)			
5	VINCAS DULYS		6	16 C	EDARWOOD	LANE -	CROWNS	VILLE.	MD 2	21032		
	20a, METHOD OF DISPOSITION		_				DATE	20c. LOCATION				
	1 X Burial 2 Cremation 2 Ren	novel from State			OF DISPOSITION (Na					lown, State		
	4 Denation 6 Other (Specify)		LOUDO	N PA	RK CEMET			BALTIN	IORE			
	21. SIGMATURE OF FURNITURE SERVICE LI	CENSEE	111			D ADDRESS OF FA		E TMC				
	b /	4	14	2		RD FUNER						
	/ flusc	/	(V)	_						E, MD 21229		
	23. PAIT i. Entar the diseases, or shock, or heart failure.				not anter the mo	da of dying, aud	h aa cardlad	or reaplicatory	arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Fine)	List Only One Cause	OII GUCII III							Onset and Death		
	disease or condition	C -	1		Can	. 0 0-				12 year		
	reaulting in death)	e	R AS A CONSE									
1		552 15 (5.	- AD A 00110E1	JOENOL O	. ,-					i		
Z	Sequentially list conditions,	b										
CERTIFICATION	If any, leading to immediate	DUE TO (OF	AS A CONSE	DUENCE O	IF):							
S	Cause. Enter UNDERLYING CAUSE (Disease or Injury	C										
<u>u</u>	that initiated events	DUE TO (OF	R AS A CONSE	DUENCE O	IF):							
E	resulting in deeth) LAST	d										
8												
	PART II. Other algnificant condition	na contributing to de	eth but not i	eaulting	in the underlyin	g cause given in	Part i. 24	a. WAS AN AUTO		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
DICAL							Ι,	YES 2 W		COMPLETION OF CAUSE		
0							I ,	L 123 . K.		OF DEATH?		
ME										1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUS				UNCERTAI	иП					
X	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEA	TH (Check only one)							
Sic	1 TES 2 NO	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER:	ne 5 Residence	6 Other (S	(beclfy)				
<u></u>	27. MANNER OF DEATN	28a. DATE OF IN.		28b, TIN		-		IBE NOW INJURY	OCCURED			
2 Accident Investigation M 1 YES 2 NO												
								I Route Number,				
1	4 Homicide determined					_				-		
Ш	29a. CERTIFIER	SICIAN: To the best of my	. becombedes of						Carried .			
P	(Critick Orlly									DAY WEST ARREST		
COMPLETED	2 MEDICAL EXAMIN	ER: On the beels of exer	nination end/or	Investigati	on, in my opinion, o	leath occured at the	time, data an	d place, and due	to the cause	e(s) and manner as stated.		
E	29b. SIGNATURE AND TITLE OF CERTIFIE	ER O				29c. LICENSE NU	MBER	29d.	DATE SIGNE	ED (Month, Day, Year)		
8	Toras Os	Kalow	la	11	2	027	938		101	114/95		
0	30. NAME AND ADORESS OF PERSON W	HO COMPLETED CAUSE	OF DEATH //TE	M 27) /5-	a Print)	- /	,		1 -1	, , , , -		
						E 202	OT ENT	יידומוו	MD 0	1061		
	DR. MAYER GORBAT			KUA	D - SUIT	E 203 -	GLEN E	JUKNIE,	MD 21	1001		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S										
1 8	II OCT 🤉 0 1995 - 🦠	IN WELLER	Carlell									

ill. Page is may be retained by the hospital or attending physician. LTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

uneral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 towns and other than the retained by the attending physician and complete, the partial of the part of the physician and complete, in removal.

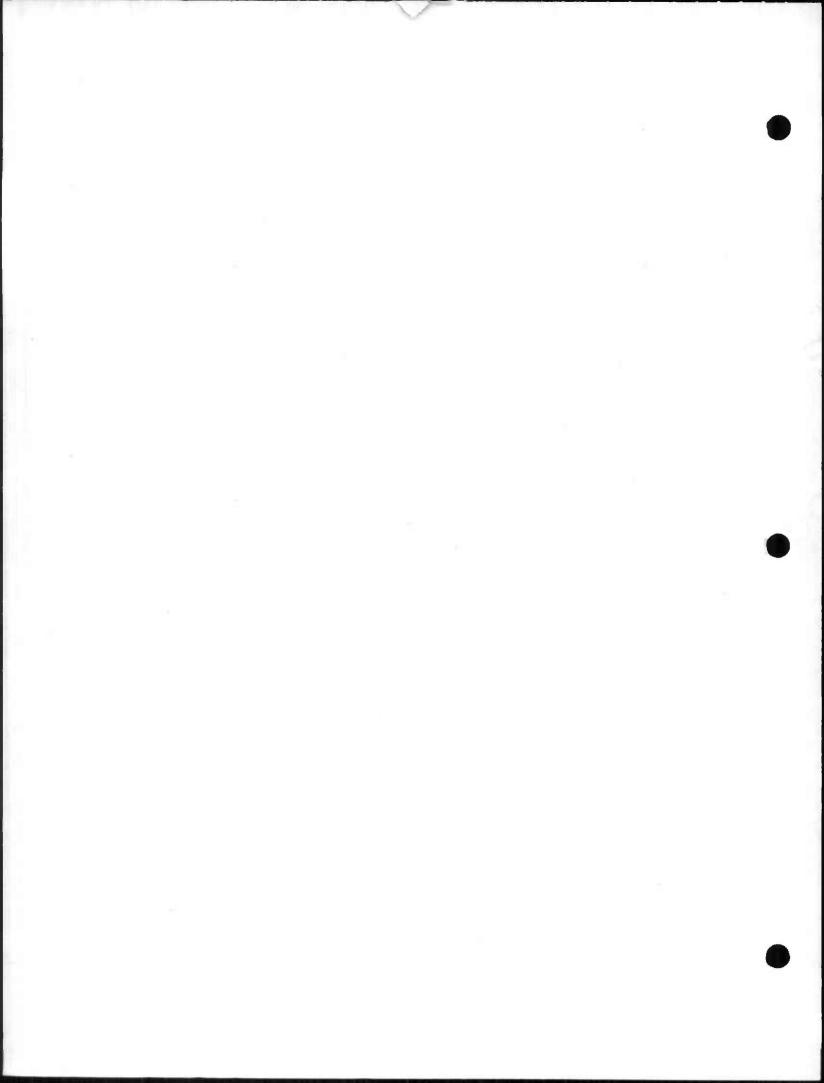
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERT	TIFICA	TE OF	DEATH		REG. NO.			
- b	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		VEAD	3. TIME OF DEATH
	DONALD Halsey	7	DAVISON	Ţ			OCT.	16	$\ddot{5}$, 1	995	10:40 P.m
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last birth	iday) IF U	NOER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	ВІЯТН	•	8. BIRTH	IPLACE (State or Foreign
	141-09-8357	1 € M 2 □ F	77 Y	RS. MONT	THE DAYS	HOURS MIN.	(Month, I		918	Countr	w Jersey
	9e. FACILITY NAME (If not institution, give s	treet and number)		9b.	CITY, TOWN	OR LOCATION OF DE	ATH		9c. COL	INTY OF D	EATH
TOR	Stella Maris			Ti	moniu	n			Ва	ltimo	ore
DIRECTOR	Maryland Balt:		104		WN OR LOCAT			:			10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER				101	. ZIP CODE			10g. Cl	TIZEN OF Y	VHAT COUNTRY?
FUNERAL	9133 Field Road				_ :	21208			U	.S.A.	
5	11. MARITAL STATUS		T EVER IN U.S. ARMED			ENDENT OF HISPAN			or No-		E American Indian, k, White, etc.
ВУ	1 Never Married 22 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 □NO MAR OR DATES WWII			2√∑NO Specify		an, etc.j		Spec	fly:
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPONENTS			AL OCCUPATION		16b. K	IND OF BU	SINESS/IN	DUSTRY	
E.	Elementary/Secondary (0-12)	College (1-4 or 5 -	life Do I	VOT use reti	red.)	at or worning					
AP.	12		Manage	er, S	elf E	mployed	Au	tomo	tive		
ő	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Mic	ldle, Maiden	Surname)		
BE (Halsey Mac	Gregor	Davison			Antoir				Ander	sen
TO E	19a. INFORMANT'B NAME (Type/Print)					and Number or Rural F	Route Number	City or Tow	n, Stete, 2	ip Code)	
	Mrs. Hildegarde Da	avison	_			- #10f	1				
į	20e. METHOD OF DISPOSITION 1 □ Buriel 2 ☆ Cremetion 3 □ file 4 □ Donation 6 □ Other	over from State	competery, cremato			o. 10-18-	-95	1		Mary	
Ï	21. SIGNATURE OF FUHERAL SETTING	hospital	-		22. NAME A	ND ADDRESS OF FA	CILITY				
	Frnest We	et, III				Towson Fu York Rd.,			•		
=	23. PART i. Enter the disesses, or	complications the								-	Approximata
ı l	shock, or heart failure. IMMEDIATE CAUSE (Finst disease or condition	List only one cau			C 200	Y-00					Onset and Daeth
	resulting in desth)	o. PUE TO	OR AS A CONSEQUEN		CAI	LER					syrs.
z		b	(on no n concede.	IOE 01).							0
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEQUEN	ICE OF):							
2	CAUSE (Disesse or Injury	C	(OR AS A CONSEQUEN	ICE OE:							
E	that initisted events resulting in desth) LAST	552.15	(OI) NO N OUNDEDUC								
S		d									
	PART II. Other significant condition	ns contributing to	death but not resu	iting in th	e underlyin	g cause given in	Part I.	4a. WAS AN		248	WERE AUTOPSY FINDINGS
DICAL							_	T YES	NO.		COMPLETION OF CAUSE OF DEATH?
ME											1 TYES 2 NO
ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEATH	YES	ON [UNCERTAIL	N 🗆				
SA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF								
PHYSICIAN:	1 TYES 2 NO		☐ ER/Outpatient 3 ☐ [00A 4 E	HER: Nursing Hor	ne 5 🗆 Residence	6X Other	(Specify)	Hos	spice	е
	27. MANNER OF DEATH Natural 5 Pending	28a. DATE OF (Month, I		b. TIME OF INJURY	W	JURY AT ORK?	28d. DESC	RIBE HOW	INJURY O	CCURED	
В	2 Accident Investigation	280 PLACE	OF INJURY — At home,	form steen			261 1 004	ION /Chant	and Numb	or or Pum!	Route Number,
TED	3 Suicide 8 Could not be 4 Homicide detarmined	building.	atc. (Specify)	(at III), active	i, lactory, orn			Town, State		er or norer.	House Nomber,
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best o	f my knowledge, death	occurred at	the time, dat	end place, and due	to the caus	e(a) and me	nner aa s	tated.	
NO.	anal	ER: On the basis of r	examination end/or inves	itigation, in	my opinion,	death occured at the	1lme, data s	nd placa, a	nd due to	the cause(a) and manner as stated.
E C	29h SIGNATURE AND TITLE OF CERTIFIE	R	0 .			29c. LICENSE NUI	MBER		29d. D/	ATE SIGNE	D (Month, Day, Year)
8	Prendall	Stan	lecen	W.	,	DAS	1,42	5	10	0/17	195
5	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAL	ISE OF DEATH (ITEM 27) (Type, Prin	nt)					1	
	DR. KENDALL F	AULKNER	2300 D	ULAN	EY V	ALLEY R	D.,	rows	ON,	MD	21204
4	OCT 2 0 1995	32. JEGISTR	AR'S SUNATURE								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host TO THE FUREALD INFECTION. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State Dept. of Health and Mential Hygiene prior to burial, certificate has the marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	NTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)		<u></u>				OF DEATH			. TIME OF DEATH	
	Grete1	Darnel		Oct.17,1995 YEAR 6:				6:00pmm			
		5. SEX 6. AGE (I	6. AGE (In yrs. lest birthdey) FUNDER 1 YEAR FUNDER 24					7. DATE OF BIRTH 8. BIRTHPLACE (State			
	234-32-6168 9e. FACILITY NAME (If not institution, give stre	1 ☐ M 2 ☒ F 7	HOURS MIN.	June19,1922 West			tVirginia				
TOR	Franklin Woods	,	ome		1e		Blatimore				
DIRECTOR	10e. STATE 10b. COUNTY Md .	Baltimore		ITY, TOWN OR LO	Rose	dale	le			Od, INSIDE CITY LIMITS? YES 2 XNO	
FUNERAL	100. STREET AND NUMBER	Dood			101. ZIP CODE 21237					AT COUNTRY?	
N.	1802 Weyburn	I U.S. ARMED	21237						I. RACE — American Indian.		
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced							White, etc.			
	15, DECEDENT'S EDUCA			'S USUAL OCCUP		16b	. KIND OF BUS	SINESS/INDU	STRY	WIIICE	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	use retired.)	during most of working							
MP	12th Assembly Line					Bendix					
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA						
BE	Charles Williams Amanda MacIntosh 19a. INFORMANT'S NAME (TyperPrint) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co.						Parela l				
2	Raymond T.	Darnoll			ırn Road					1237	
	20e. METHOD OF DISPOSITION	206		EOFDISPOSITION		DAT		CATION - CI			
	1 Burlet 2 Cremetion 3 Removed 4 Donation 5 Other (Specify)	val from State cem	etery, cremetory or	other plece)		1					
	4 Donation 5 □ Other (Specify) Gardens of Faith 10/21/95 Rossville Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE // 22. NAME AND ADDRESS OF FACILITY										
	Connelly Funeral Home of Essex										
	23. PART I. Enter the diseases, or co	omplications that caused	the death. Po	not enter the	Mace Av	e Ba	1 time	ro M	d	21221 Approximate	
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) Onset and Death										
	disease or condition meta static lung concer										
- 1	DUE TO (OR AS A CONSEQUENCE OF).										
S O	Sequentially list conditions, Due to (or as a consequence of):										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING										
E	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
	resulting in death) LAST										
	PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS										
CAL	CAN II. One agrinicant conditions contributing to death but not resulting in the underlying cause given in Part i.						PERFORMED? AVAILABLE I COMPLETIO		WAILABLE PRIOR TO		
EDI							1 YES 2 NO OF DEATH?				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							YES 2 NO			
¥.	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
SIC		HOSPITAL: 1 Inpetient 2 ER/Outp	etlent 3 DOA	OTHER: 4 Nursing I	ome 5 - Reeldence	6 🗆 Othe	er (Specify)				
ŘΙ	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		1	INJURY AT WORK?		SCRIBE HOW	NJURY OCCU	JRED		
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Monor, Day, Today)			YES 2 NO						
	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, lerm, street, lectory, office building, stc. (Specify)					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				ute Number,	
	4 Homicide determined										
COMPLETED	one)	IAN: To the best of my know									
8	2 MEDICAL EXAMINER: On the besie of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner ee stated.										
BE	296. SIGNATURE AND TITLE OF CERTIFIER	~ //					NSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 10 - 18 - 95				
6	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								0-17		
	KRISTINE (FLAIR	RI	RA	17711	NOF	= 21236	
	31. DATE FILED (Month, Day, Year)	P. RECISTRAR'S SIGN	- 1	4-16		1-	13/19	-OI IM		-1-30	
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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the second of the control of the c	Injury, or other traumatic ev
the death	d, or item 23 shows any injury, or other traumatic

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lust) 2. DATE OF DEATH 3. TIME OF DEATH 995 GRIMES BETTY RAMSEY 11:01 OCTOBER 16 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Sept. 23, 1921 Washington, DC 1 🗌 M 2 🔀 F 74 578-20-2691 YRS 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH PRINCE GEORGE'S Cheverly DIRECTOR Prince George County Hospital RESIDENCE OF DECEDENT 10a STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Edgewater MD Anne Arundel 1 X YES 2 NO FUNERAL 104 STREET AND NUMBER 101. ZIP COOE 21037 iog. CITIZEN OF WHAT COUNTRY? 1423 Park Road USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 YES 2 NO Specify Specify: White ВҰ 3√ Widowed 4 ☐ Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname Unknown Unknown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1291 Cape St. Claire Rd, Annapolis, MD 21401 Nadine Snyder 20s. METHOD OF DISPOSITION
110 Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Davidsonville U.M. Church10/20 Davidsonville, MD 21, SIGNATURE OF FUNERAL SERVICE LICENSER 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A 12 Ridgely Ave. Annapolis, MD 21401 23. PART I. Enter the dissess, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Daath shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Mypeardial Infarction, Acute bue to (or as a consequence of): disease or condition resulting in death) minutes Generalized ATKenoscleratic Candivascular Dis CERTIFICATION Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 1 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 | Nursing Home 5 | Realdence 6 | Other (Specify) 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO ΒY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER (Check only one)
2 No MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Dotoker 16, 1995 & Benger MD 125925

7720 WISCONSUL AVE

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

#205

J. BERGER MO

31. DATE FILED (Month, Day, Year)

01995

Bethesda, md 20814

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	TTENDING PHYSICIAN:	TOR: After this certifical	28 is marked, or ite
	OR ATTENDING PHYSICIAN:	MRECTOR: After this certifical	em 28 is marked, or ite
	AL OR ATTENDING PHYSICIAN:	AL DIRECTOR: After this certifical	if item 28 is marked, or ite
	SPITAL OR ATTENDING PHYSICIAN:	VERAL DIRECTOR: After this certifical	IT: If item 28 is marked, or ite
	HOSPITAL OR ATTENDING PHYSICIAN:	FUNERAL DIRECTOR: After this certifical	ITANT: If item 28 is marked, or ite
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted to burish 72 hours after death with the State heart, or Heath and Mental Horiene ofter to burial cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	ITEM: 1. PER F.H.	FILM g-72	8 10/20/9	5 t.t	/ O. F.				,) (11401	
	ITEM: 1. PER F.H. FilmG, 728 FOR STATE REGISTRAR	STATE OF M	IĀRYLAND /	DEPAR	RTMENT	TOF H	EALTH DEAT	AND I	MENTA	L HYGIEN	E			
	1. OECEDENT'S NAME (First, Middle, Last)	G	ERARD						2. DATE	OF OEATH	Y	YEAR	3. TIME OF DEATH	
	ERIC ERICK	×66	RALD	GR	EENE	3			OCT	.16,1		Teen	19:41 PM	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE	OF BIRTH		Country	PLACE (State or Foreign	
	215-70-3501	1 XM 2 - F	27	YRS.						18,19			land	
· ·	9e. FACILITY NAME (If not institution, give a					r, TOWN O			EATH			NTY OF OE	ATH	
DIRECTOR	JOHNS HOPKINS	HOSPITA	L SICU		BA	LTI	MORI	3			1	N/A		
E C	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN	OR LOCAT	ION					T	10d. INSIDE CITY	
E I	Maryland	N/A		Bal	timo	re							LIMITS?	
A A	10e. STREET AND NUMBER					10f.	ZIP COD	CODE 10g. CITIZEN OF WHAT				HAT COUNTRY?		
FUNERAL	442 Ilchester Av	enue			21218					U.S.A.				
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea FORCES? 1 YES 2 NO If yea, specify Cuban, Maxican, Puerto Rican, atc.)					or No-	r No- 14. RACE — American Indian, Black, White, etc.								
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	MR OR DATES	•0		1 YES		Specify		recan, atc.)		Specify	ifty:	
	15. DECEDENT'S EDUC	047/01/	T 40						Lon				Black	
H	(Specify only highest grade	completed)	(G	ive kind of Do NOT u	work done	during mos	in st of workin	ng	168	. KIND OF BUS	SINESS/INC	USTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +	.)	LAB0						CONS	TRUC1	TION		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First,	Middle, Maiden	Surname)			
Ü.	Thomas Lovette									Green				
00	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	nd Number	or Rural i	Route Num	ber, City or Town	n, State, Zip	Code)		
5	Alice Greene 442 Ilchester Avenue/Baltimore, MD 21218													
	206. PLACE AND DATE OF DISPOSITION 1 WAurisl 2 Cremetton 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of Correction Commence of Commen													
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	- 0716	11110						e East		,,,,	110	
	· V	72	1										03.000	
	/ aren		Los	ar									MD 21202	
	23. PART i. Enter the diseases, or cashock, or heart failure.	List only one cau	se on aach ilne	ath. Do	not enfe	r tha mo	de of dy	ing, auc	h as car	diac or reapi	ratory an	reat,	Approximata interval Between	
	disease or condition resulting in death) a. MUTPLE GUNSHOT WOMDS									Onset and Dasth				
	resulting in death)		OR AS A CONSE			L U	JUW	VVVS	-					
_	_		(STI NO IT OOTIOE											
RTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
8	CAUSE (Disease or injury													
틸	that initiated events	DUE TO	(OR AS A CONSE	DUENCE C	IF):									
I III I	resulting in death) LAST													
C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS													
EDICA										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
밀										1 (5) 123 2	□ NO		OF DEATH? 1 VES 2 □ NO	
. M	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH Y	ES 🗆	NO [UNC	ERTAI	N \square				7.00	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
Sic	EXAMINER? NO 1 NO 1 NO 1 NO 1 NO 1 NO 1 NO 1 NO													
РНҮ	27. MANNER OF DEATH 28s. DATE OF INJURY 28s. THE OF 28s. IN HIRVAT 28s. DESCRIPTION OF COLUMN AND C													
ВУР	1 Netural 5 Pending 2 Accident Investigation													
	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, ferm, etreef, factory, office 28s. LOCATION (Street and Number or Rural Route Number, Wildling after (Specific)								oute Number, M)					
ETE	4 Homicide determined		2	PEE	7			3014 VINEYARD LANE BALTIMORI						
	29a. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of	my knowledge, de	eath occur	red at the	time, deta	and place	, and due	to the ce	use(e) end mer	mer ea atel	led.		
COMPL	2 MEDICAL EXAMINE	Ry Oe the basis of a	nation and/or	Investigati	on, in my	opinion, d	eath occu	red at the	time, dat	a and place, an	d dua to th	ne cause(s)	and manner as stated.	
I III I	29h. BIONATURE AND TITLE OF CERTIFIED						29c. LIC	ENSE NUI	MBER		29d. DAT	'E SIGNED (Month, Day, Year)		
0 8	mun 4	Zalle	1/1/2					OCN	ΜE		00	CT.1	7,1995	
IF	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATHLITE	M 27) (7vo	Print1									

31. DATE FILED (Month, Day, Year)

OCT 2 0 1995

32. REGIST 111 Penn Street, Baltimore, Maryland 21201 32 REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last) Linwood K Grahar	n						2. DATE OF DEATH OCT 13, 1995 YEAR 2:20AM				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a. BIRTHPLACE (State or Foreign					
	242-64-2554 9a. FACILITY NAME (If not institution, give st	1 M 2 🗆 F	54 YRS.	MONTHS DAYS	HOURS MIN.		15, 1941 North Ca					
S.	11818 Moores Driv	ele	oc. county of Death Allegany									
ᇤ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
DIRECTOR		llegany	100.017	La Val				LIMITS?				
	10e. STREET AND NUMBER				. ZIP CODE		10g. CIT	IZEN OF WHAT COUNTRY?				
FUNERAL	11818 Moores Drive				2150	2		USA				
BY FU	11. MARITAL STATUS 1 Never Married 2 🕅 Married 3 Wildowed 4 Divorced	J.S. ARMED 2 XNO ES	If yes, sp		NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.) y:	Black, White, atc. Specify:						
		CATION	S. DECEDENTIE	ISLEEL COOLIDATE		Tank white on the		Black				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				st of working	16b. KIND OF BUS	SINESS/INC	DUSTRY				
립	High School					CSXT R	ailro	ailroad Company				
S S	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Malden						
BE (Levi Graham					Morrison						
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow						
	Brenda H. Graham			Moores				land 21502				
	20s. METHOD OF DISPOSITION 1 Aburial 2 Grandian 3 Removal from State 4 Donation 5 John State 20b. PLACE AND DATE OF DISPOSITION (Name of commellery, crymptory or other piece) Mt Vernon Prsebyertian Cem 19 Rowan, North Carolina											
	21. SIGNATURE OF FUNERAL PRIVICE LICENSES 22. NAME AND ADDRESS OF FACILITY NUTTER FUNERAL HOMES, Inc.											
	+ Kane 1	My A	ulth	2501	Swynns F	alls Parkw	ay 216					
	23. PART I. Fittar the diseesea, or co	omplications that caused t	ha death. Do no	ot entar the mo	da of dying, suc	h as cardiac or reapi	ratory an					
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Sy au	100	m	Cl	ml	M	Interval Between Onset and Death				
_		DUE TO (OR AS A C	ONSEQUENCE OF)					(
2	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
<u>გ</u>	CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):											
ERTIFICATION	that initiated events reaulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF)	:	1-00-0							
	o. Oct 13,1995											
¥	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMILIABLE PRIOR TO											
MEDIC	TEN OHMED! MAIEAGE PRIOR TO							COMPLETION OF CAUSE				
	1 YES 2 NO											
CIAN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YELEASED		PLACE OF DEATH		UNCERTAI	иЦ						
	EXAMINER? Teleased	HOSPITAL: 1 Inpetient 2 ER/Outpeti		OTHER:	S X Basidanca	6 Other (Specific)						
PHYS	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME				28d. DESCRIBE HOW INJURY OCCURED					
BY	Natural 5 Pending Accident Investigation	(100101, 00), 1001)	, into		ES 2 NO							
	3 Suicide 6 Could not be 4 Homicide detarmined	At home, ferm, at	At home, ferm, street, factory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLET	29a. CERTIFIER (Check only (Check only (Check only) (Check only (Check only) (Check											
8	one) 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dus to the cause(s) and manner as steted.											
шШ	296. SIGNATURE AND TITLE OF CERTIFIER	_			29c. LICENSE NUI	MBER	29d. DAT	E SIGNED (Mont), Day Abar)				
	Strice 25	·			1012	(1)	>	0/13/5(1				
-	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, I	Print)		1						
	Cumberland Memori	al Hospital	n:		Cumbe	rland, Mar	ylan	đ				
	OCT 2 0 1995	LA SORDINGER MARK										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

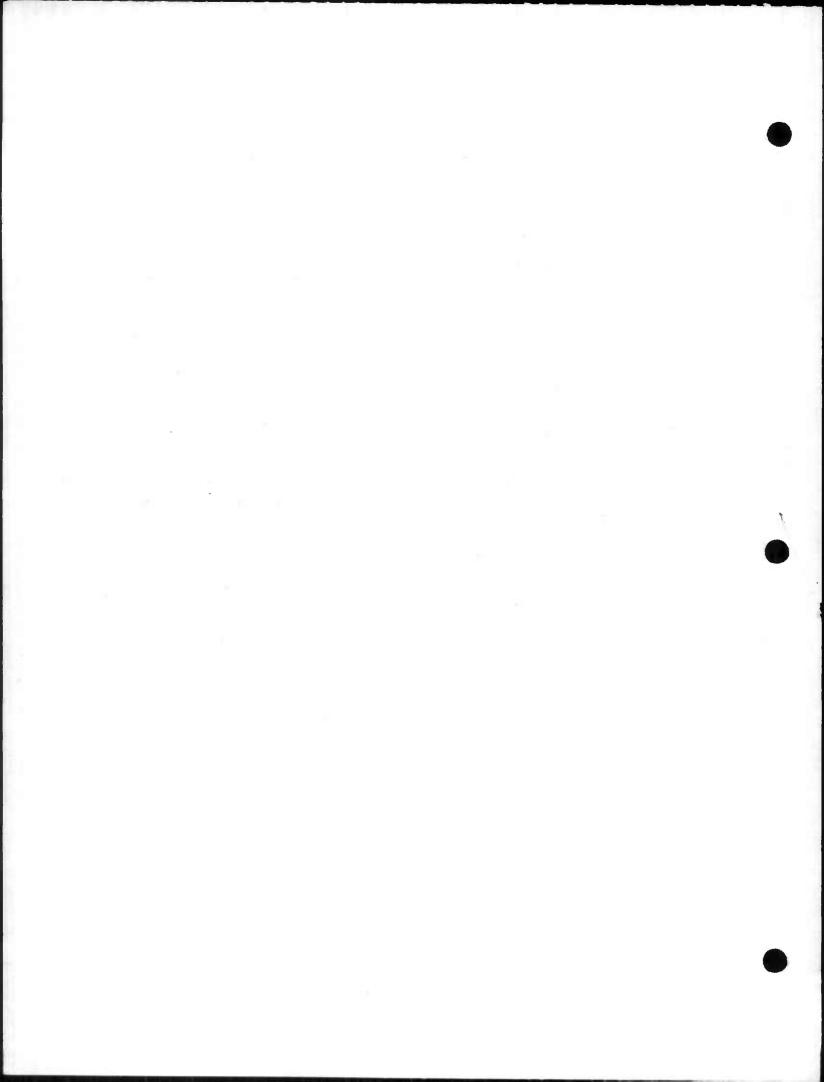
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within the State Deat, or Health and Merital Horisian nor in burial contraining or sensors.

1 -

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REG. NO.		
2. DATE OF DEATH	1 QQYEAR	3. TIME OF (

	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH	3. TIME OF OEATH 01:00 P.
	Margaret Griffin	October 15, 199	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 H 1. 10 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	(Adamsh Day Man)	BIRTHPLACE (State or Foreign Country)
	24-64-0367 1 M 2 PF 32 YRS.	JAN. 2/9/13/	MRYIMD
l nc	9e. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION O		Y OF DEATH
DIRECTOR	The Johns Hophins Hospital Baltimore (City/	Y/M
) iii	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY
1 2	MD. N/A BALTIMORE		1 FYES 2 NO
AL	10e. STREET AND NUMBER	10g. CITIZI	EN OF WHAT COUNTRY?
iii iii	2212 ROUND KD. 212	25 11	19,19
FUNERAL		ISPANIC ORIGIN? (Specify Yea or No-	14. RACE American Indian, Black, White, etc.
×	3 Wildowed 4 Divorced IF YES, OIVE WAR OR DATES 1 YES 2 NO S	Specify:	BIAK
G	15. OECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION	16b. KIND OF BUSINESS/INDU	STRY
	(Specify only highest grade completed) [Give kind of work done during most of working life, Do NOT use retired.) [Give kind of work done during most of working life, Do NOT use retired.)	2/2000	20)
4 4	12TH VIETARY	1907/1	1/
once.	17. FATHER'S NAME (First, Middle, Light)	'S HAME (First, Mickelle, Maicher (Griname)	0
10 m	PARCHIE K. PULLOCK	LDRED HARRI	5
be notified		Butal Route Namber City or Town, State, Zip (2000)
n o	DEVIT PAULOCI 1777 MILES IV	WAICI MALL	1111.4219
TS n	20. FLACE AND DATE OF DISPOSITION (Name of the foundation of the f	Physics 20g LOCATION — C	ity or Town, State
5	4 Donation 5 Only (Specify) 21. SIGNATURE OF PLACEAL SERVICE LICENSEE 22. MARK AND ADDRESS.	14/77 14/1/517/	Who I'm
in in	SORY!	MARCH TUMBER	1901/12 111
ex .	X10mg /1- // /me 270 1980	HILTON MASS PAL	I, MT, 21229
medical examiner must	23. PART They the Obsesses, or complications that caused the death. Do not enter the mode of dying shock, or heart fallure. List only one cause on each line.	such as cardiac or respiratory arre	Approximate interval Between
	IMMEDIATE CAUSE (Final disease of condition		Onset and Death
T, T	a. Disse winated in a brante viden out to constant viden out v	avium intracellular	e Tyear
or other traumatic event, the	0	andre an	
ry, or other traumatic	Sequentially list conditions, b. Hequired immunudo Ficiency Sy	navona	a years
trau TA	If any, leading to immediate cause. Enter UNDERLYING	J	
The state of the s	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):		
	resulting in death) LAST		
		en in Part I. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
vs any inju	Dehydration	PERFORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
2 E		1, X YES 2 NO	OF DEATH?
99	DID TORACCO LISE CONTRIBILITE TO CALISE OF DEATH YES TO NO TINICED	TAIN []	1 1 123 2 30 110
n 23	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)		1
Her	EXAMINER? 1 YES 2 10 THER: 1 YES 2 10 THER: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 10 Nursing Home 5 Residence 10 Nursing Home 5 Residence 10 Nursing Home 5 Nursing Home 5 Residence 10 Nursing Home 5 Nursin	ence 6 Other (Specify)	
is marked, or item 23 D BY PHYSICIAN	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28s. TIME OF 1NJURY AT WORK?	28d. DESCRIBE HOW INJURY OCC	URED
marke BY F	12 Transfer 3 Personno M 4 VEO 6 N	10	
is ma		28f. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,
ANT: If item 28 is	4 Homicide determined		
Item I	29a. CERTIFIER (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, an	nd due to the cause(s) and manner as state	d.
NT: H	One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured	at the time, data end place, and due to the	ceuse(s) and manner as stated.
E H	29b. SIONATURE AND TITLE OF CERTIFIER 29c. LICENS	E NUMBER 29d. DATE	SIONED (Month, Day, Year)
IN PO	Atom of her	23	to be v 15, 1995
F	81	1.1	
		s Hoptims Hospita	
٦	31. DATE FILED (Month, Dey. Year) 32. REGISTRAR'S SIGNÁTURE		
_	OCT 2 01995 Self Devilor Robert		



Pages 1, 2, 3 should

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detached once.

3 F

page 5 should notified

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must

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In will

31. DATE FILED (Month 1995")

OCT 2

llas

Michael Purtell M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thysuca

REGISTRARY LIGHT ATURE

BALLIMOR	Nours after death. Page 6 ma	Ned in by the funeral director, or removal.	e medical examiner must
DIVISION OF VITAL MECONDS, T.O. BOX 88700	TO THE HOSPITAL OR AITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 ma	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 STANLEY BERNARD GARDNER October 18 2:15 A M 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 XM 2 - F 219-10-4750 69 4-13-1926 Maryland Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7613 Cypress Ave. Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21224 USA 7613 Cypress Ave. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify, Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 ZANO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced WW II 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life, Do NOT use retired.) П Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Diesel Mechanic Railroad 17. FATHER'S NAME (First Middle Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James V. Grzechowiak Mary V. Rybarczyk 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Alberta Gardner 7613 Cypress Ave. Baltimore, Md. 21224 20a METHOD OF DISPOSITION
1 N Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Holly Hill Memorial 10-21 Baltimore, Md. 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk olt Inthony 7110 Sollers Point Rd. 21222 23. PART I. Enter the distances, or complications that caused the yearh. Do not enter the mode of dying, such as cardiac or respiretory strest, shock, or heart failure. List only one cause on each line. Intarval Between Onset and Death IMMEDIATE CAUSE (Final helandic disease or condition_ resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated aventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 TES 2 NO t | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t Matural 5 Pending 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 - Could not be COMPLETED 4 Homicide 29a. CERTIFIER (Check only one)

One)

MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. MGNATORE AND TITLE OF CERTIFIER

4940 Eastern Ave.

29c. LICENSE NUMBER

D19714

29d. DATE SIGNED (Month, Day, Year)

Baltimore, Md. 21224

10/18/95

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

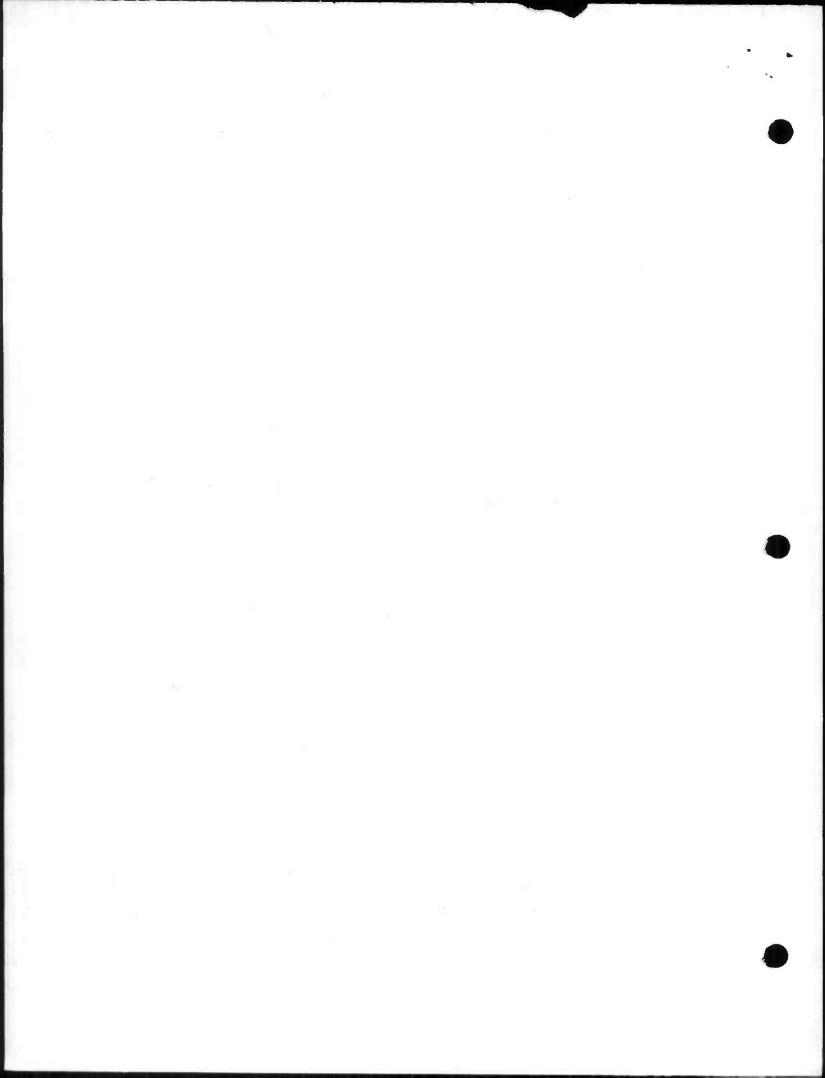
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	REGISTRAR	TIFICAT	E OF	DEATH	F	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF MONTH	DEATH DAY	No.	3.	TIME OF DE	EATH		
	ELIZABETH B. HARN				Oct.		199	5"	7:35	P . M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birt)	hday) IF UNDE	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	8.	BIRTHPL	ACE (State or	Foreign		
	218-22-0263 1□ M 2 X F 73 Y			HOURS MIN.		3, 19	922 M	Country) [ary]				
	9a. FACILITY NAME (If not institution, give street and number)	9b. CIT	Y, TOWN OF	LOCATION OF DE	ATH		9c. COUNTY	OF DEAT	Н			
FUNERAL DIRECTOR	206 Glen Ave.	Sa	lisb	ury			Wic	omi	00			
E	10a. STATE 10b. COUNTY 10	c. CITY, TOWN	OR LOCATIO	ON				10	d. INSIDE C	ITY		
5	Maryland Baltimore	Pik	esvil	le				1	YES 2	NO NO		
A.	10e. STREET AND NUMBER			ZIP CODE			10g. CITIZEN	OF WHA	T COUNTRY	7		
EB.	724 Templecliff Road			21208			1	U.S.,	Α.			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO	13.		NDENT OF HISPAN			or No- 14.		American In	ndlan,		
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced FYES, GIVE WAR OR DATES		1 TYES	2 NO Specify	r.	m, ww.,		Specify.	White	2		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give ki	ENT'S USUAL (ind of work done NOT use retired.)	OCCUPATION o during mos	N t of working	16b. KI	NO OF BUSI	NESS/INDUS	TRY				
	Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retired.,)									
₩ M	4 Years Off:	ice Pe	rsonn	el	Pi	kesvi	11e 0:	fic	e Sup	ply		
8	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAI	ME (First, Midd	dle, Maiden S	umame)					
BE (L. Creston Beauchamp			Anne Da								
5	19a. INFORMANT'S NAME (Type/Print)	AILINO ADDRES	9S (Street an	d Number or Rural F	Route Number,	City or Town,	State, Zip Co	cle)				
		Old Fa	arm L	ane New								
	20e. METHOD OF DISPOSITION 1 □ Buriel 2 ⊕ Cremation 3 □ Removal from State Comparison Comp				OATE		ATION — City					
				Service		Ham	pstead	1, M	D			
	21. SIGNATURE OF UNEITAL SETU CE LICENSEE			address of failing Byers		. 1 D4	maata	***	Tas			
	X Antirus		8728	Liberty	Road	Rand	allst	own.	MD 2	21133		
	23. AR7 i. Enter the diseases, or complications that caused the death abook, or heert failure. List only one cause on each line.	. Do not ente	er the mod	le of dying, aucl	h se cerdis				Approx			
	Image: Constituent Image:											
_	- D Heaton Brief Campaia											
CERTIFICATION	Sequentially liet conditions, If any, leading to immediate											
¥	cause. Enter UNDERLYING	notom	itar	nl Cov	well							
F	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUER	NCE OF):										
H	resulting in death) LAST											
	PART II. Other algnificent conditions contributing to death but not resu	delmo lo dho c		aguas aluan In	Post I o	la. WAS AN A	LITORAN	0.45 34	ERE AUTOPS	V PAIDINGS		
DICAL	PART II. Other arguinteen conditions continuously to death but not read	iting in the t	underlying	Cense diven in	Pert I. 24	PERFORM		AN	MILABLE PRI	OR TO		
ğ					— l¹	YES 2	No		F DEATH?	or Glose		
ME								1	YES 2	NO		
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH			UNCERTAIN	и 🗆 📗							
PHYSICIAN:	EXAMINER? / HOSPITAL:	OTHE	ER:		1 600		_					
YS	1		-	5 Residence								
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Chetural 5 Pending	Bb. TIME OF INJURY	28c. INJL WOR		280. DESCH	IIBE HOW IN	JURY OCCUP	IEU				
В	2 Accident Investigation	form elevat to			201 LOCATI	ON /Street or	od Alumbas as	Durent Days	to Mumbar			
COMPLETED	3 Suicide 6 Could not be determined building, etc. (Specify)											
E	29a. CERTIFIER Check cold. CERTIFYINO PHYSICIAN: To the best of my knowledge, death	occurred at the	time date	and place, and due	to the cause	(a) and many	ner as stated					
MP	(Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation.								nd manner e	e stated.		
8												
BE	29b. SIONATURE AND INTEREST CERTIFIER			29c. LICENSE NUI	WBER -	,	29d, DATE 9	IGNED (M	onen, Day, Ye	par)		
5	20 NAME AND ADDRESS AS STROPHY WAS COME.	7.7- 7		10 10	00/		- 10	118	143			
	30. NAME AND ADDRÉSS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27		+S	alich		mal	7/	201				
	31. DATE FILED (Month, Day about	0113	1,0	unso	ury	rru	0/1	701				
	OCT 9 0 1995											

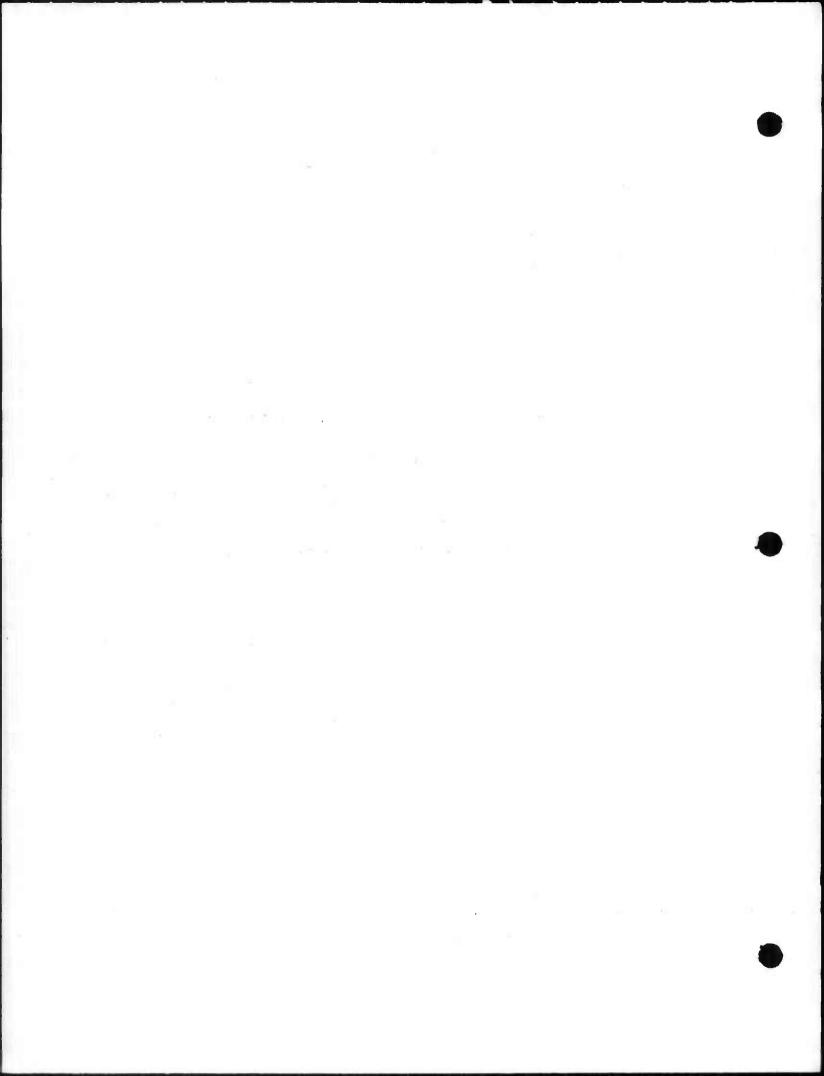


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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. 3 should

	1 - STATE REGISTRAR	STATE OF MARYLAND		TMENT DF I		MENT	AL HYGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DA	TE OF DEATH			3. TIME OF DEATH
	Betty	H	Н	ALLER		Oc t	ober 19	199	5	4:12 a м
	ACT 10 1001		O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURIE MIN.	7. DA	TE OF BIRTH	8.	BIRTHE Country AT	Abama
œ	9a. FACILITY NAME (If not institution, give stre			9b. CITY, TOWN	OR LOCATION OF D			9c. COUNTY		
DIRECTOR	Franklin Square	HOSPITAL			Rossvil	Te.		Ba1	time	ore
REC	10a. STATE 10b. COUNTY		10c. CIT	, TOWN OR LOCA	TION					10d. INSIDE CITY LIMITS?
		Baltimore		Ba1	timore					1 TES 2 NO
FUNERAL	1805 Crafton Ave	÷ .		10	21222			10g. CITIZEI	US	HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If you, or	ENDENT OF HISPA ecity Cuban, Maxic 2 XNO Speci	an, Puer	GIN? (Specify Yea to Rican, etc.)	or No- 14	. RACE Black, Specify	American Indian, White, etc. White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	ATION ompleted) 16a.	(Give kind of w life. Do NOT us	USUAL OCCUPATI vork done during me e retired.)	ON est of working	1	16b. KIND OF BUS		TRY	713.12.00
MP	7th 17. FATHER'S NAME (First, Middle, Lest)		Hous	ewife				home		
BE CO	Robert Hunter				Sus	ie l	t, Middle, Melden S Ford	,		
5	19a. INFORMANT'S NAME (Type/Print) Rosina Mary Severs	son			n Ave. B					
j	20a. METHOD OF DISPOSITION 1 □ ② □ Cremation 3 □ Ramov 4 □ Donation 8 □ Other (Specify)	rel from State cametery	cremetory or of	OF DISPOSITION (Na ther place)	emetery			CATION — CITY		rn, Stata Florida
	21. SIONATURE OF FUNERAL SERVICE LICE	WSEE OTHER S	lda me	conne	POMPTERS OF FA 11y Fune ace Ave.	ral	Home of	Esse	x	
	23. PARY I. Enter the diseases, or co	mplications that caused the st only one cause on each-	death. Do n	ot enter the mo	de of dying, aud	ch as c	ardiac or respir	ratory arrest	144	Approximate
	IMMEDIATE CAUSE (Final	Atherosclerot	ic vas		isease					Interval Between Onset and Death
NO	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
ICAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury									
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):						
AL C	PART II. Other significent conditione	contributing to death but no	ot resulting i	n the underlyin	g ceuse given in	Part I.	24s. WAS AN /	WTOPSY	24b.	WERE AUTOPSY FINDINGS
DICA	Dementia						PERFORI			AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YE	S NO	UNCERTAL	<u> </u>				1 YES 2 NO
CIAI	25. WAS CASE REFERRED TO MEDICAL	26. PI		H (Check only one)					_	
YSI	1 YES 2 NO	HOSPITAL:	3 DOA	OTHER: 4 - Nursing Hore	e 5 🗆 Rasidenca	8 🗆 01	her (Specify)			1.00
ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	URY WO	URY AT RK? /ES 2 NO	28d. C	EŞCRIBE HOW IN	JURY OCCUR	ED	
	3 Suicide 8 Could not be datarmined	28a. PLACE OF INJURY — All building, etc. (Specify)	home, farm, s	treet, factory, offic		281. Li	OCATION (Street ar fty or Town, State)	nd Number or	Rural Ro	oute Number,
COMPLETED		AN: To the best of my knowledge, On the basis of examination and/							euse(a)	and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	v1			29c. LICENSE NU			N .	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO William Tidmore M.I	0.9000 Frankli	n Squa	re Driv	e Baltim	ore	MD 212			
	OCT 2 0 1995	32. REGISTBAR'S SIGNATURI	E L							



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DS, P.O.
RECORDS
OF VITAL RE
1 OF
DIVISION

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
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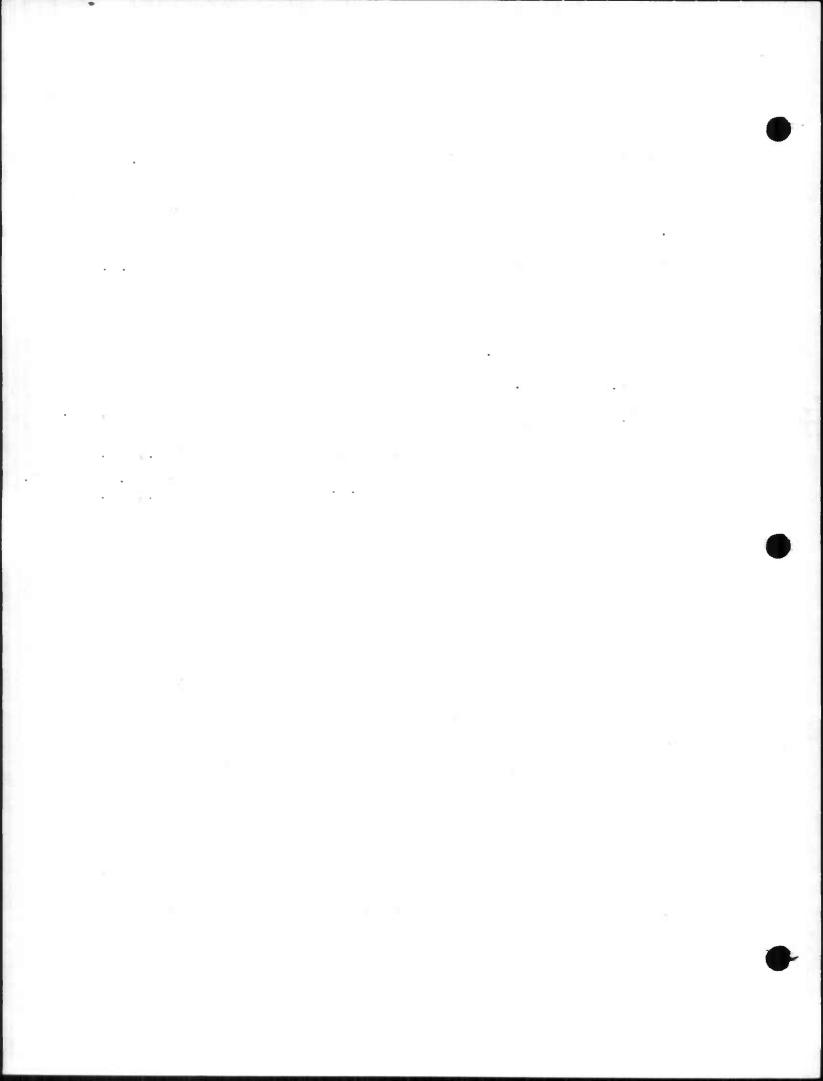
	1 - FOR STATE REGISTRAR	E OF MARYLAND / DEPAR CERTIFI	TMENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, (ast)	1		2. DATE OF DEATH DON'TH DON'TH	17.1992	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX $215-22-9659$ 1 \square M	6. AGE (In yrs. lest birthday) 2 F 8 3 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	1912 8. BIRTI	HPLACE (State or Foreign
OR	98. FACILITY NAME (II not institution, give street and no	soital	96. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF C	DEATH A
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY	TOWN OB-LOCATION			10d. INSIDE CITY
	104 STREET AND NUMBER	+	Balto 101, ZIP CODE		Luc airean	1 X YES 2 NO
FUNERAL	900 n- Woods	ngton Rd	2123	29	10g. CITIZEN OF	S. A
BY	1 Never Married 2 Married FORG	DECEDENT EVER IN U.S. ADMED DES? 1 YES 2 NO S, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAI If yes, specify Cyben, Mexica 1 YES 2 W NO Specify	n, Puerto Rican, etc.)	or No— 14. RACI Blac Spec	E — American Indian, k, White, etc.
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary(Secondary (0-12) College	(1-4 or 5+) 16a. DECEDENT'S ((Ghv kind of w (inc. Do NOT post)	USUAL OCCUPATION ork done during most of working or retired.)	166. KIND OF BUS	ealty	
COM	17-FAINER'S NAME (First, Middle, Last)	1		ME (First, Migdle, Maiden	Syrname)	
BE	194. INFORMANT'S NAME (Type/Print)	JUCI NS	ADORESS (Street and Number or Rural I	na	Doyal	
10	Arthur E.	Pierce 48:	39 Branch	leigh Ro	n. State, Zio Code)	0 md 2/133
	29a, METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State 20b. PLACE AND DATEO ceinetery crematory or bit	er place)	192495 LO	CATION - CHY or TO	own, State
	31, SIGNATUBE OF FUNERAL SERVICE LICENSE	1	22, HAME AND ADDRESS OF EA	ETY H WO	sta	
	23 PART I show the diseases or compliant	Impan J	2 4300 1	vabas	L AD	e
	23. PART I. The the diseases, or complicate the city, or heart fallure. List only IMMEDIATE CAUSE (Finel	one cause on each line.	or enter the mode of dying, suc	h aa cardlac or reapi	ratory arrest,	Approximate interval Between Onset and Death
	disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF	ry Disease	>		
NO	Sequentially list conditions, b.					
CATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF)	:			
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF)	:			
	PART II. Other algnificant conditions contrib	uting to death but not required in	Marine di Antonio			
ICAL	Breast Mass, a	suspect carcivo		Part I, 24s. WAS AN PERFOR	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC	Brain Mass 31	repect metas	ases	_	700	OF DEATH?
IAN	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL	TO CAUSE OF DEATH YES	OCHOCK ONLY ONE)	1,5		7.
YSIC			OTHER:	6 Other (Specify)		
	1 Natural 5 Pending	OATE OF INJURY (Month, Day, Year) 28b. TIME INJU		28d. DEŞCRIBE NOW II	NURY OCCURED	
ED BY	2 Accident Investigation 3 Suicide 6 Could not be datarmined 28a.	PLACE OF INJURY — At home, farm, sti building, etc. (Specify)		261, LOCATION (Street a City or Town, State)	nd Number or Rural F	loute Number,
COMPLETED	29a. CERTIFIER (Check only	e best of my knowledge, death occurred	at the time, date and place, and due	to the cause/s) and mo	nor no eleted	
MOC	one) 2 MEDICAL EXAMINER: On the b	easis of examination and/or investigation	In my opinion, death occured at the	time, data and place, and	d due to the cause(s) and manner as stated.
띪	296. SIGNATURE AND TITLE OF CENTIFIER	Addical Resort	20c. LICENSE NUM	BER 027	29d. DATE SIGNED	(Month, Day, Year)
일	30. NAME AND ADDRESS OF PERSON WNO COMPLE	TEO CAUSE OF DEATN (ITEM 27) (Type, F		4	Calor	0-1911/3
	31. DATE FILED (Month, Day Nov) 22.	DINAL HOSPITAL	Baltimore,	Maryland	1	
	OCT 2 1 1995	luction hardes		•		

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BALTIMORE, MARYLAND 21215-0020

I	tem:11	per	informant	G-748	6/11/97	dh
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	1 - FOR STATE REGISTRAR	STATE OF MA					EALTH /			YGIEN	E		
	1. DECEDENT'S NAME (First, Middle, La RONALD	E.	_		JONE	c			2. DATE OF MONTH OCT .	DEATH DA	199	YEAR	3. TIME OF DEATH 8:26 P. M
	4. SOCIAL SECURITY NUMBER		3. AGE (In yrs. las		IF UNDER		IF UNDER 2	4 HRS.	7. DATE OF	BIRTH	193	S. BIRTH	IPLACE (State or Foreign
	219-40-8311	1 1 M 2 □ F	51	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, D	9), Year))8 – 4	3	S.C	marolina mar
	9a. FACILITY NAME (If not institution, gi	ve street and number)			9b. CITY,	TOWN O	R LOCATIO	N OF DE	ATH		9c. COU	NTY OF D	DEATH .
DIRECTOR	RT. 32 AND CA	ATE WAGNE	R RD.		WE	STM	INST	ER			Car	roll	County
IRE	MD Ba	altimore		10c. CIT	Ran		lsto	wn					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	arcimore -					ZIP CODE	-			10g, CIT	ZEN OF V	1 YES 2 NO
ERA	3414 Courtle:	igh Drive					2124	4			Nation 1		S.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 XX Married 3 Widowed	12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA	EVER IN U.S. AF I YES 2 1 R OR DATES Airf	NO		If yes, spe		, Maxicar	IC ORIGIN? (I		or No—	14. RACI	E — American Indian, k, Whita, etc.
0	15. DECEDENT'S (Specify only highest g	EDUCATION	18a. DE	ECEDENT'S	USUAL O	CCUPATIO	N .		16b, KI	ND OF BUS	SINESS/IND	USTRY	
PLET	Elementary/Secondary (0-12)	College (1-4 or 5+) 2yrs.	Dia.	in Do NOT u	se retired.)	ounng mos	st of working	7	S	elf	Emp 1	Loye	d Nursing
E COMPLETED	17. FATHER'S NAME (First, Middle, Last) James B. Jone						18. мотн Eve	er's nai	ME (First, Mick Bry	lle, Meiden ant	Sumame)		
TO B	19a. INFORMANT'S NAME (Type/Print) Joan J. Ledb	etter	19	ь. MAILING 3414	Cou	S (Street ar	eigh	or Rural R	ive	City or Town Rand	alls	Code)	m, MD21244
100	20a. METHOD OF DISPOSITION 1	Ramoval from State	20b. PLACE cemetery, cri	ematory or o	ther placel			/10	DATE		CATION —		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE							1/95 CILITY		lto.		
	Deruta	Nect c	FSP #2	281	E	.L.	Phi1	.lip	s F/	Н ^{1/2} Ва	1-2. 1to	/ N	Monroe St MD. 21217
	23. PART I. Enter the diseases, shock, or heart failu IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. MULTIP	e on each line	JUR	IES	the mod	de of dylr	ng, suci	h es cerdiad	or respi	ratory en	rest,	Approximete interval Batween Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.												
MEDICAL C	PART II. Other significant condi	tiona contributing to d	laath but not	rasuiting	in the ur	ndarlying	g cause g	iven in		PERFOR	RMED?	248	D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2	DID TOBACCO USE CO	NTRIBUTE TO CAU	JSE OF DEA	ATH Y	ES 🔲	NO [UNC	ERTAIN	v 🗆				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:			OTHE								
IVSI	1X YES 2 □ NO	1 🗆 Inpetient 2 🗙			4 🗆 Nur	sing Hom		aldenca	8 Other (S				
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF II (Month, Da)	()bar)		JURY	28c. INJI WO 1 N	RK?	NO	OCCU	PANT	OF AL	ATO 1	NVOLVEP, IN
ED BY	2 Accident investigat 3 Suicide 8 Could not 4 Homicide datarmina	28e. PLACE OF building, e	INJURY — At hetc. (Specify)			tory, office		`	City or	Town, State))		Route Number, MP
	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as atteted.											ted.	
MP	one) 2 X MEDICAL EXA	29c. LICENSE NUMBER 2											
BE COMPLETED	2 X MEDICAL EXA	()	hat										D (Month, Day, Year)
ш	200. SIGNATURE AND TITLE DE CERTI	Hally	OF DEATH (ITE			Str	0.0	С.М.	Е.	ore	▶0	CT.	

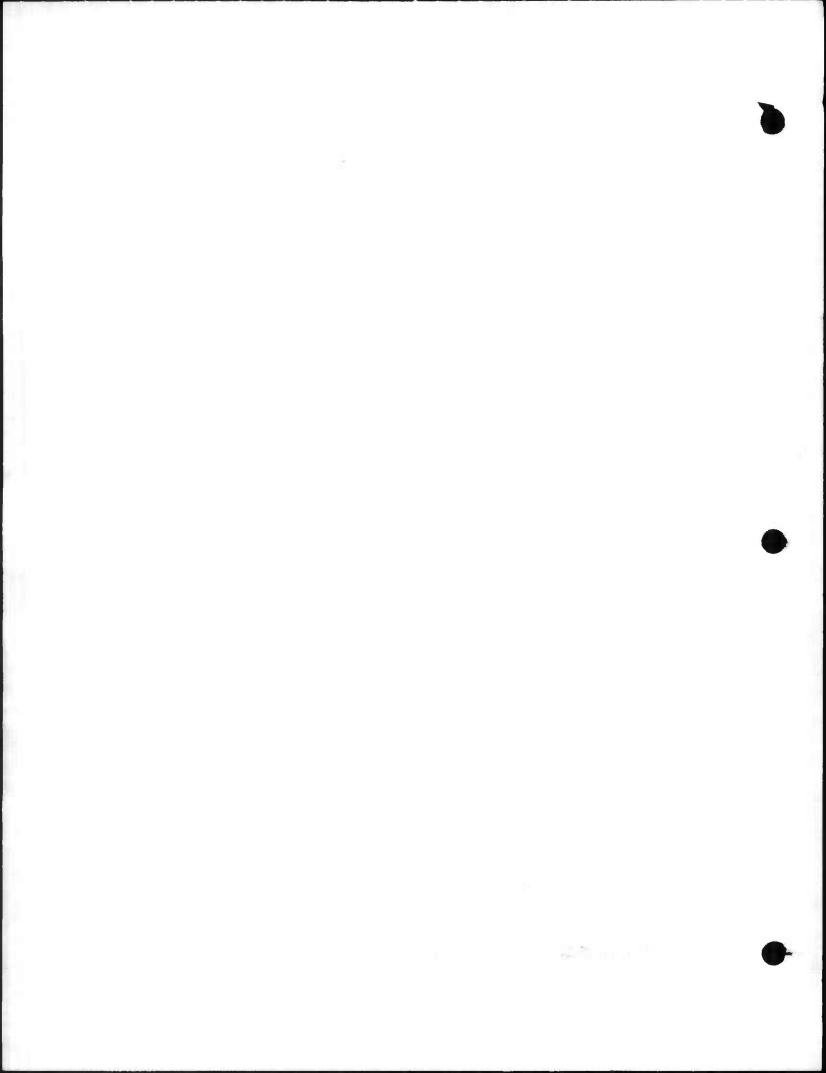


hed by the hospital or attending physician. Build be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	ATT	ECT	s af	n 26
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any included by the host	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF M	ARYLAND / DEPA		OF HEALTH		ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) AGNES R. JUMP					- 1	DATE OF DEATH OF OCTOBER 9	AV VE	3. TIME OF DEATH 1:30 a. M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest birthde)			24 HRS. 7	7. DATE OF BIRTH (Month, Day, Vear) 8. BIRTNPLACE (State or Fon Country)				
	579-18-4814	1 M 2 X F	73 YRS.	MONTHS	DAYS HOURS	MIN.	Sept. 19,		laryland		
œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	3254 Gleneagles Drive Silver Spring Montgomery RESIDENCE OF DECEDENT MONTGOMERY										
RE	10s. STATE 10b. COUNT		1000	TY, TOWN OR					10d. INSIDE CITY LIMITS?		
	Maryland Mont	gomery	Sá	lver S				,	1 YES 2 NO		
FUNERAL	3254 Gleneagles D	k i u o			20906				OF WHAT COUNTRY?		
S	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED	13. W	S DECENDENT O	F HISPANIC	ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian,		
BY F	1 Never Married 2 Married 3 Widowed 4 X Divorced	FORCES? 1	YES 2 NO	10	nes, specify Cuber	n, Maxican, I Specify:	Puerto Rican, etc.)		Black, White, etc. Specify: White		
ED B	15. DECEDENT'S EDU	ICATION	16a. DECEDENT	e (letta), 000	INATION						
E	(Specify only highest grade	College (1-4 or 5+)	(Give kind o	work done du	ing most of working	g	16b. KIND OF BUS	SINESS/INDUST	RY		
COMPLET	12	College (1-4 of 5+)	Legal	Secret	ary		Lo	w Firm			
Ö	17. FATNER'S NAME (First, Middle, Last)	2			18. MOTH	ER'S NAME	(First, Middle, Malden	Surname)	1/		
B	Samuel Jeremiah F	(Son)					Adele Rar		9		
2	Donald H. Jump	(3011)	4514	Chase	Street and Number AUCHUC	or Aural Aou -Beth	esda, Ma	n, Stete, Zip God Lyland	20814		
	20a. METNOD OF DISPOSITION 1										
- 1	4 DOnation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIFE	CENSEE RONALE	Wade. Dir	22.NA	MF AND ADDRES	S OF EACH	ITY				
	Anual B.	1/2	+	Sta					timore Street 1201-1559		
	23. PART I. Enter the disesses, or	complications that	csused the deeth. Do								
	ahock, or heart failure. IMMEDIATE CAUSE (Final	List only one caus	e on/each line.			1			Interval Between		
	immediate cause (Final disease or condition resulting in death) a. Was Vatic Bruas Cancer Syears										
	DUE TO (OR AS A CONSEQUENCE OF):										
HTIFICATION	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
8	cause. Enter UNDERLYING CAUSE (Disease or injury	c									
E	that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEQUENCE	OF):							
US I	d										
A	PART II. Other significent condition	ns contributing to	death but not resulting	In the unde	erlying cause g	iven in Pa	rt I. 24e. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
EDIC							1 - YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?		
Σ	DID TOBACCO USE CONT	DIDLITE TO CAL	ICE OF DEATH V	TC [] N		EDTAIN		- 1	1 YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAL	26. PLACE OF OE			EKIAIN					
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3 🗆 DOA	OTHER:	g Home 5 🗆 Res	sidenca 6	Other (Specify)				
РНҮ	27. MANNER OF OEATN	28a. DATE OF I (Month, Day	NJURY /, Year) 26b. Ti	1	c. INJURY AT WORK?	_	d. DESCRIBE NOW I	NJURY OCCURE	0		
BY	1 Netural 5 Pending 2 Accident Investigation				1 YES 2						
ED	3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF building, e	INJURY — A1 home, farm tc. (Specify)	street, lactory	, office	26	City or Town, State)	and Number or Ru	ural Route Number,		
LET .	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of n	ny knowledge, death occu	red at the time	, data and place.	and due to	the cause(s) and men	oper as stated			
COMPL									use(s) and menner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	WI	11		29c. LICE	NSE NUMBE	n n	29d. DATE SIG	MED (Month, Day, Year)		
TO 8	0	Hm	VIL		D:	339	93	•			
-	39, NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE	OF DEATH (ITEM 27) (7)	e Print)							
	31. DATE FILED (Month; Ony Year)	32. REGISTRAR	'S SIGNATURE								
	OCT 2 0 1805	10	dear Roll								
_		The arms	THE PERSON NAMED IN						DHVH 15 Day 1700		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the floath leads in the floath of the case of the hospital or attending physician.

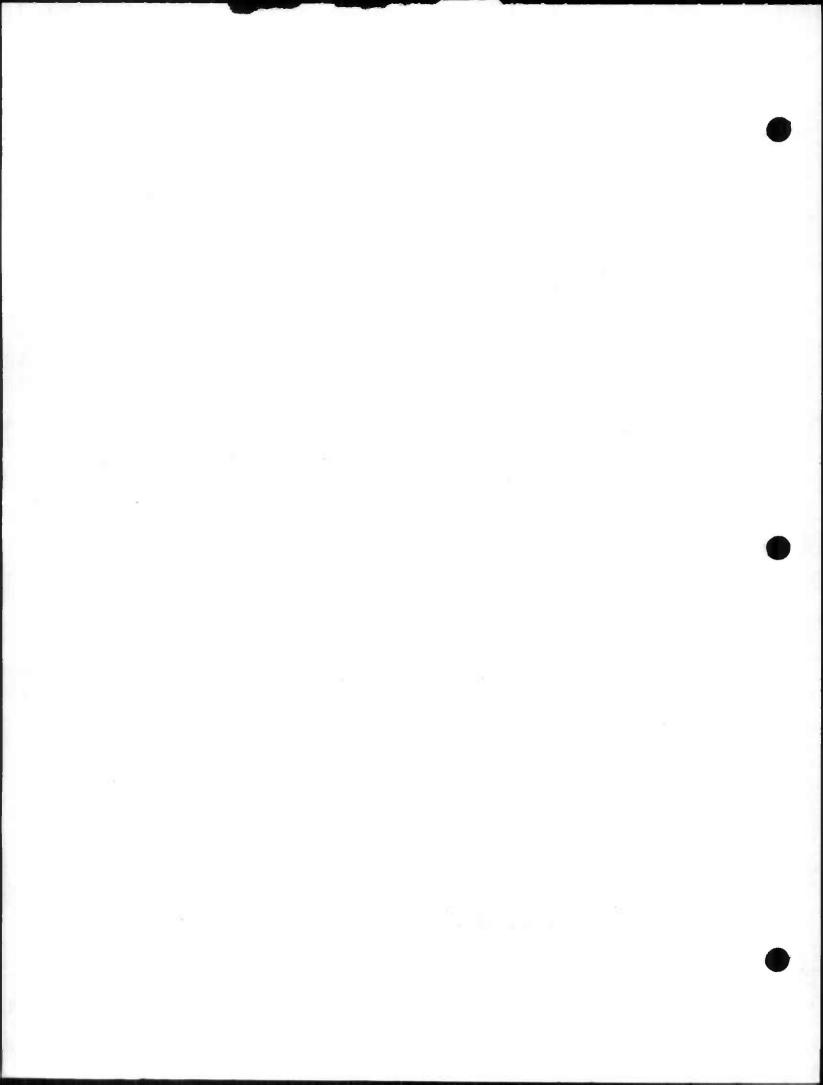
TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENI
	CE	ERTIFICATE	OF DEAT	ГН		REG. NO.

1 - FOR STATE REGISTRAR	TATE OF MARYLAND /	DEPARTMI			MENTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
John Michael	Jones				October 1	5,1995	3:45pm M
4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (In yrs. les		NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. B	IRTHPLACE (State or Foreign ountry)
220-74-1551 1 9e. FACILITY NAME (If not institution, give street a	x ^{M 2 □ F} 38	YRS. MONT		HOURS MIN.	Mar. 17,19		laryland
	,	90.		R LOCATION OF DI	EATH	9c. COUNTY C	timore
500 Vogts Lane				SSEX		Dal	CIMOLE
10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	ON			10d. INSIDE CITY
Md. Bal	timore			Essex			1 YES 2 NO
10e. STREET AND NUMBER			10f.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
500 Vogts Lane				21	221	υ	ISA
	WAS DECEOENT EVER IN U.S. AR FORCES? 1 YES 2 X				NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No.— 14. F	RACE — American Indian, Black, White, etc.
	IF YES, GIVE WAR OR DATES			2) NO Specif			Specify:
15. DECEDENT'S EDUCATION	N	1					White
(Specify only highest grade comp	pieted) (G	CEDENT'S USUA ive kind of work of Do NOT use retir	ione during mos	N at of working	16b. KIND OF BUS	INESS/INDUST	₹Y
Elementary/Secondary (0-12) Co	ollege (1-4 or 5 +)						
17. FATNER'S NAME (First, Middle, Last)	lyr	Wait	er	18 MOTNED'S NA	AME (First, Middle, Maiden	Rester	aunt
Charles Jones					velyn Wi		
19a. INFORMANT'S NAME (Type/Print)		h. MAILING ADD	RESS (Street a)		Route Number, City or Town		
Albert Jones					litmore 1		221
20a. METNOD OF DISPOSITION		AND DATE OF DIS				CATION — City	
1 Surisi 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State cemetery, cre	matory or other p	lace)				
21. SIGNATURE OF FUNERAL SERVICE LICENS	EE / I HOLLY	AHIII	22. NAME AN	O ADDRESS OF FA	0/19/95 1	Saltin	lore Mo.
R Till	NU NI	//	Conne	elly Fu	neral Ho	ne of	Essex
23. PART I. Enter the diseases, or com-	Jonnell	4		_			
shock, or heart felium List	only one ceuse on each line	ath Do not e	nter the mo	ds of dyling, suc	h as cardiac or raspi	ratory srrest,	Interval Between
IMMEDIATE CAUSE (Final disease or condition	Davissad	Down	ממונ	MARION	marie Con	no don	Onset and Death
resulting in death)	Acquired.	מיון נוען	11161	127/00	uney Sy	10101	THE TYRS
	DUÉ TO (OR AS A CONSE	OUENCE OF):			/ '		1
Sequentielly list conditions, b	DUE TO (OR AS A CONSE	OLIENCE OED:					
if any, leading to immediate cause. Enter UNDERLYING		oction of j.					
CAUSE (Disease or injury that initiated events	OUE TO (OR AS A CONSE	DUENCE OF):					
resulting in death) LAST							
0							
PART II, Other significant conditions co	ontributing to death but not	resulting in th	e underlying	ceuse given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
	1711	276(1	(1)	12/2	1 D YES 2	NO	COMPLETION DF CAUSE OF DEATN?
(4/0maga (20)	rus Retir	7/7/5	unu	(DITT)	15		t 🗆 YES 2 🗀 NO
DID TOBACCO USE CONTRIB				UNCERTAI	N 🗆		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLAC	CE OF DEATH (C	heck only one)				
1 VES NO 1	Inpatient 2 ER/Outpatient 3	DOA 4	Nursing Hom		6 Other (Specify)		
27. MANNER OF DE)TH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY		PK7	28d. OEŞCRIBE NOW 1	NJURY OCCURE	D
Accident Investigation		<u> </u>		ES 2 NO			
3 Suicide 6 Could not be 4 Nomicide datermined	26a. PLACE OF INJURY — At he building, etc. (Specify)	oma, larm, atreet	, lactory, office		261, LOCATION (Street and City or Town, State)		ural Route Number,
(Crieck Crist)	N: To the best of my knowledge, de						
MEDICAL EXAMINER: O	on the besis of exemination and/or	Investigation, in	my opinion, d	eath occured at the	time, deta and place, an	d due to the ca	use(a) and manner as stated.
290. SIGNATURE AND TITLE OF CERTIFIER	Ollection			29c. LICENSE NU	MBER	29d. DATE SIG	DAREC (MOVIE) Day (Mag)
DICHURY	HOME/			17368	514	10	117/45
35. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF SEATH (ITE	M 27) (Type, Print	1)	30 1-1-	Mr 71	7 211	
1600 USIEGH	A SUM	34.	100	レンプリ	110 4	0-74	
31. DATE FILED (MOVING 995)	MI-MERENYAR'S SIGNATURE						
UUTA							



BALTIMORE, MARYLAND 21215-0020 Introdeath. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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Cert	ding	Hydi	r 0t
eath	aften	ntai	У, о
the death	the atten	Mentai	njury, o
hat the death	d by the atten	and Mentai	ny Injury, o
res that the death	igned by the atten	ealth and Mental	rs any injury, o
equires that the death	en signed by the atten	of Health and Mental	hows any injury, o
aw requires that the death	s been signed by the atten	ept. of Health and Mental	3 shows any Injury, o
The law requires that the death	e has been signed by the atten	te Dept. of Health and Mental	em 23 shows any Injury, o
N: The law requires that the death	ficate has been signed by the atten	State Dept. of Health and Mental	r Item 23 shows any injury, o
SICIAN: The law requires that the death	certificate has been signed by the atten	the State Dept. of Health and Mental	1, or Item 23 shows any Injury, o
PHYSICIAN: The law requires that the death	this certificate has been signed by the atten	with the State Dept. of Health and Mental	rked, or Item 23 shows any Injury, o
ING PHYSICIAN: The law requires that the death	After this certificate has been signed by the atten	leath with the State Dept. of Health and Mental	marked, or Item 23 shows any Injury, o
ENDING PHYSICIAN: The law requires that the death	JR: After this certificate has been signed by the atten	ter death with the State Dept. of Health and Mental	8 is marked, or item 23 shows any injury, o
ATTENDING PHYSICIAN: The law requires that the death	ECTOR: After this certificate has been signed by the atten	rs after death with the State Dept. of Health and Mental	n 28 is marked, or item 23 shows any injury, o
. OR ATTENDING PHYSICIAN: The law requires that the death	DIRECTOR: After this certificate has been signed by the atten	hours after death with the State Dept. of Health and Mental	Item 28 is marked, or Item 23 shows any Injury, o
PITAL OR ATTENDING PHYSICIAN: The law requires that the death	:RAL DIRECTOR: After this certificate has been signed by the atten	n 72 hours after death with the State Dept. of Health and Mental	f. If Item 28 is marked, or Item 23 shows any Injury, o
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death	FUNERAL DIRECTOR: After this certificate has been signed by the atten	within 72 hours after death with the State Dept. of Health and Mental	TANT: If Item 28 is marked, or Item 23 shows any Injury, o
HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death	HE FUNERAL DIRECTOR: After this certificate has been signed by the atten	iled within 72 hours after death with the State Dept. of Health and Mental	ORTANT: If Item 28 Is marked, or Item 23 shows any Injury, o
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Ι	tem29b,Film728,10/20/95,1t	DVI AND	/ DEDAD	TMENT OF	JEAITH AND I	MENTAL	HYCIEN	E		
	1 - STATE STATE OF WA			CATE OF		WENTAL	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) TROY 5_ K	ISAn	NORE	.5R.		2. DATE O		19	YEAR 95	3. TIME OF DEATH 923 PM
		MONTHS DAYS HOURS MIN. (Month,				PERTN Day, Year)	925	8. BIRTNPLACE (State or Foreign Country) W. VIRGINIA		
_	9a. FACILITY NAME (If not institution, give street and number) (GREENE ST) 9b. CITY, TOWN OR LOCATION OF DE							9c. COU	NTY OF DE	ATH
DIRECTOR	VETERANS ADMINISTRATION MED	CTR	BALT	MORE			BA	LTIMO	RE CITY	
IREC	100, STATE 100, COUNTY MARYLAND BALTIMORE C	T 0337	10c, CITY	, TOWN OR LOCA						10d. INSIDE CITY LIMITS?
	MARYLAND BALTIMORE C	TIY			LTIMORE of. ZIP CODE			10g. CITI	ZEN OF W	YES 2 NO
FUNERAL	545 S. LONGWOOD STREET				2122	3		ı	J.S.A	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT FORCES? 1 X	VER IN U.S. / YES 2 OR DATES	1 TES 2 NO Specify: Specify:					— American Indian, White, atc. WHITE		
밀	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			USUAL OCCUPAT		16b.	KIND OF BUS	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) 7 TH GRADE		ine. Do NOT us ONTRAC	e retired.)	tired.)					
BE CO	17. FATHER'S NAME (First, Middle, Last) GARY KISAMORE			18. MOTNER'S NA PEARLI						
TO B	19a. INFORMANT'S NAME (Type/Print)	- 1			and Number or Rural					
	TROY E. KISAMORE 606 N. CHURCHILL ROAD - BELAIR, MD. 210 20e, METHOD OF DISPOSITION 1 A Burlet 2 Cremetton 3 Removal from State camplery, cremetory of other place) DATE 20c. LOCATION - City or Town, cremetory of other place)									V = 1
	4 Donetion 5 Other (Specify) MEADOWRIDGE MEMORIAL PARK 10/2D ELKRIDGE									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE WHITE COLORS 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE,								MD 21229	
	23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): LACUTE Renal Failure 24 days 23 days DUE TO (OR AS A CONSEQUENCE OF): COVORANY Artery Disease									
PHYSICIAN: MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in P Peripheral Vascular Disease							AUTOPSY RMED?	24b.	WERE AUTOPSYFINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 _ YES 2 NO
AN:	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL			S X NO The Check only on		иПІ				6
SICI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inputant 2 E			OTHER:	me 5 Residence	6 🗆 Other	r (Specify)			
РНҮ	27. MANNER OF DEATN 28a. DATE OF IN (Month, Day,	IJURY Year)	28b. TIM	JURY V	JURY AT	28d. DE\$	CRIBE HOW	INJURY OC	CURED	
BY	2 Accident Investigation 26e, PLACE OF	INJURY — At	home, farm, i	M 1	YES 2 NO	281, LOC	ATION (Street	and Numbe	r or Rural R	oute Number.
TED	3 Succee 8 Could not be building, at 4 Homicide datarmined	c. (Specify)					or Town, State,		-	
COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of m									and manner as stated,
ш	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
TO B	Clute 11 tah m	0			D-476	21 097	787	1	0/16	195
-	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE 22 S. Greene	OF DEATH (1	tem 27) (Type		O Chri	stiar	м. F	ishe	r, M.	D.
	OCT 2 0 1995 July Driver	SIGNATURI	E							

.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the funeral director, page 6 may be retained by the horizon physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEN				
٦	1. DECEDENT'S NAME (First, Middle, Last)		OZIII II IO	AIL OI	DEATH	2. DATE OF DEATN		YEAR .	3. TIME OF DEATN	
	Carl John Koge	lschatz				October 1	10:55 P M			
	4. SOCIAL SECURITY NUMBER	SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HR							LACE (State or Foreign	
	212-90-3431								faryland	
-	9e. FACILITY NAME (If not institution, give st				R LOCATION OF DE	EATN		NTY OF DE		
2	3815 Sweet Air Rd	. •		Phoen:	LX		Balt	imor	3	
DINECTOR	10a. STATE 10b. COUNTY		10c, CITY, 1	OWN OR LOCAT	ION				10d. INSIDE CITY	
5	Maryland Balt	imore	Phoe	nix					LIMITS?	
_	10s. STREET AND NUMBER			101	ZIP CODE		10g. CITI	ZEN OF WI	HAT COUNTRY?	
LONELAL	3815 Sweet Air Rd	l.		2	1131			USA		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN				HC ORIGIN? (Specify Ye	e or No-	14. RACE	- American Indian,	
- 1	1 Never Married 2 Merried	FORCES? 1 YES			25 XNO Specify	n, Puerto Rican, etc.)			White who.	
	3 Widowed 4 Divorced								white	
	15. DECEDENT'S EDUC (Specify only highest grade		16e. DECEDENT'S US (Give kind of work	k done during mo	N st of working	18b. KIND OF BU	ISINESS/IND	USTRY		
4	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	,		. Manakia	7 7 20-			
Cimre		+4	Martial	Arts II				-5		
3	17. FATHER'S NAME (First, Middle, Last)	_				ME (First, Middle, Malder ia Miller	Surneme)			
4	Harry Kogelschat 190. INFORMANT'S NAME (Type/Print)	.Z	1							
2						Route Number, City or Tox oenix Md.				
	Diane Kogelschatz									
	1 Buriel 2 Cremetion 3 Remo		PLACE AND DATE OF LEGISLATION OF COMMENTS				des,		n, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC		. Joins C		ID ADDRESS OF FA		des,	PICE.		
	· Kull	PX_	-		Ruck To		reon N	1d 2	1 2 0 4	
ICALICIA	23. PART I. Enter the diseases or compilections that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximately list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or in									
	thet initieted events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Lemphila A source								lefelong	
* MEDICAL C	PART II. Other algnificant condition					PERFO 1 YES	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
H SICIAIN.	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	-						
3	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outs		THER:	e 5 Nastdenra	6 Other (Specify)				
	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME (OF 28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OC	CURED		
	1 Netural 5 Pending	(Month, Day, Year)	NJUR	M 1 .	RK? YES 2 NO					
	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	Accident investigation Suicide 6 Could not be 28a. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify)							oute Number,	
IMPLE	and only	CIAN: To the best of my know							end manner se stated.	
3	29b. SIGNATURE AND TITLE OF CERTIFIER	0			29c. LICENSE NUI	MBER	29d. DAT	E SIGNED	Month, Day, Year)	
	Charles Pos	al mb			DC 13		1	olia	195	
2	2150 Rom	CRAIS M'E	KASSLE	R-		oshing	for I	10	20037	
	OCT 2 0 1995	32 REWINTRAR'S SIEN	ATURE			0	-			

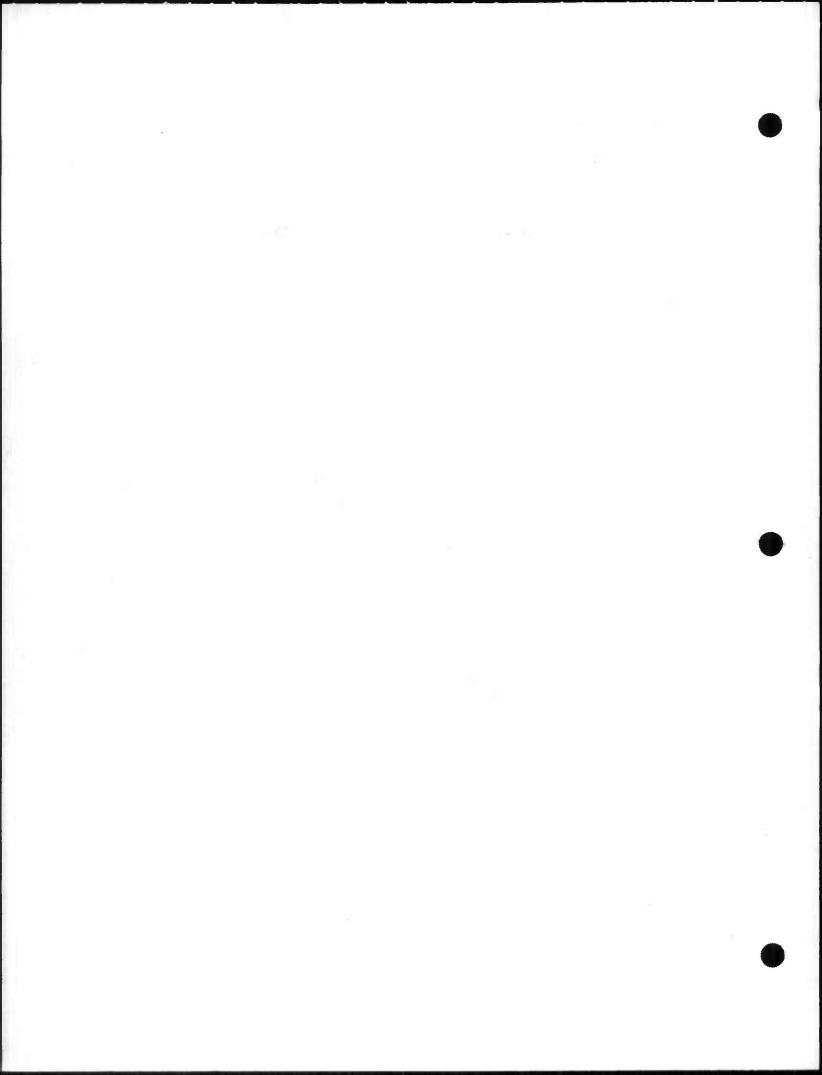
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH													
		Walter	Char1	es	KANT	ER					Octob	er 1	7,19	YEAR	1:38 P M
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yr:	s. lest birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF	BIRTH	,,,,,	8. BIRTH	PLACE (State or Foreign
-0:		219-32-764	3	1 XM 2 [] F	60	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept.		35	Country	aryland
3 should	[9s. FACILITY NAME (If not in		9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT										
oi.	DIRECTOR	Franklin				Ross	vil1	e		Ba1	timo	re			
80 80	[[[RESIDENCE OF DEC	10b, COUNT	γ		100 00	ry, town o	B I OC	ATION						
Pag	E .	Md.		Baltimo	re	100.01	Essex						10d. INSIDE CITY LIMITS?		
ermit	1	10e. STREET AND NUMBER							1 TYES 2 THO						
. sit p	FUNERAL	606 N.													
al-tra	5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF										pecify Yes	or No-	US)	- American Indian.
but a	BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 XI Y IF YES, GIVE WAR 0 58-6				Q TES 2 NO If yes, specify Cuben, Mexice					n, Puerto Rica	n, etc.)		Black Specif	, White, etc.
the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, once.												White			
use use	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)				(Give kind of life. Do NOT u	work done i	during m	ION lost of working	ng	16b, KIP	ID OF BUS	INESS/IND	DUSTRY	
pital o	1 2	Elementary/Secondary (0-12) College (1-4 or 5 +)													
detache	N N	12th 17. FATHER'S NAME (First, M	liddle, Last)			Mail	Han	dle		HED'S NA	ME (First, Midd		Ito.	Sun	
3 8 8		Walter Ka	- 1						16. WIOT				Sumeme)		
		Walter Kanter 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
after death. Page 6 may be retained in by the funeral director, page 5 should moral. Ical examiner must be notified	2	Lynn Wil									imore				
e 6 may ector, pa must b		20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)													
Page i direc		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY													
death. Pag e funeral dir I. examiner		DP T		./!	1	1.					ral Ho	me o	f Es	sex	
y the noval.	\vdash	23. PART I. Enter the diseases, or complications that caused the death, so not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate													
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		shock, or h	eart fallure	Lest only one cau	se on each.	ling	not entar	tne me	oda or dy	ng, suci	n ea cerdiac	or respii	retory arr	est,	Interval Between
20 単 20 里		iMMEDIATE CAUSE (Fir disease or condition		Urracrom	. + - 1 - + -	7									Onset and Death
od within 24 ompletely fille il, cremation, event, the		a. Hypoventilation 30min.													
	z			Нурорег	fusior	n									
an an	E	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING Obstructive lung disease													
cate physic e pric	2	CAUSE (Disease or Injury C.													
leath certificate be execut attending physician and c mal Hygiene prior to buria y, or other traumatic	CERTIFICATION	that initiated events resulting in death) LAS	SECUENCE C	DENCE OF):											
	CE														
0 E Z =	AL	PART II. Other algorifice							ng ceuse (iven in	Part I. 24s	. WAS AN		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
uires that the signed by the Health and bws any In	DICAL	Coronary a			seizur	re dis	isorder				1[YES 2			COMPLETION DF CAUSE DF DEATH?
requires een sign of Healt	ME	Cirrhosis,													1 YES 2 NO
	AN:	DID TOBACCO U		RIBUTE TO CA						ERTAIN	1 🗆				
PHYSICIAN: The law requirence this certificate has been so with the State Dept. of Hinded, or Item 23 show	2	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEA	TH (Check of)			_			
ician ertific the S	PHYSICI	1 YES 2 NO		1 x Inpatient 2 28s. DATE OF			4 🗆 Nun	ing Hor		eldence	6 Other (Sp				
7 2 5 3		1 Natural 5	Pending	(Month, D		28b. TIR	JURY	W	JURY AT ORK? YES 2	□ NO □	28d. DESCRI	BE HOW IN	JURY OCC	CUREO	
TTENDING FOR TOR: After after death	D BY	2	Could not be	28e. PLACE O	F INJURY - A	I home, term,	street, fact			,	281. LOCATIO	N (Street e	nd Number	or Rural Ro	oute Number.
	ETE!		determined	building,	atc. (Specify)						City or To	wn, State)	111		
L OR A L DIREC 2 hours f Item	PL	29e. CERTIFIER (Check only 1) CERT	IFYING PHYS	CIAN: To the best of	my knowledge	, death occur	ed at the ti	me, date	e end place,	end due	to the cause(s) end man	ner es atate	ed.	
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I	COMPL	one) 2 MEDI	CAL EXAMINE	R: On the basis of e	xemination end	f/or investigation	on, in my o	pinion, d	death occur	ed at the	lime, data end	plece, end	due to th	e ceuse(e)	and menner es stated.
THE HE FILE FILE WILL	ш	296. SIGNATURE AND TITO	OF CERTIFIE	w		7			29c. LICE	NSE NUM	BER	T	29d. DATE	E SIGNEO	(Month, Day, Year)
THE SHOOT THE SHOT THE SHOOT THE SHOOT THE SHOOT THE SHOOT THE SHOOT THE SHOOT THE SHOT THE SHOOT THE SHOOT THE SHOOT THE SHOOT THE SHOOT THE SHOT	TO B								R D	167	7		1	1/17/	95
_		36. NAME AND ADDRESS OF												0	
5		Dr. David	Trevi				are D	r.	Balti	more	, Mary	land	212	37	
7		OCT 2 0 19	95	32. PEGISTRA	AT CALL	K									





ALTIMORE, MARYLAND 21215-0020	normal are death. Page 6 may be retained by the hospital or attending physician.
AAL	fir death
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	E
BOX 68760	cate be executed will
0S, P.O.	he death certifi
RECORI	requires that t
ISION OF VITAL RECORDS, P.O. BOX 6876	ATTENDING PHYSICIAN: The law requires that the d
SION	TENDING PI

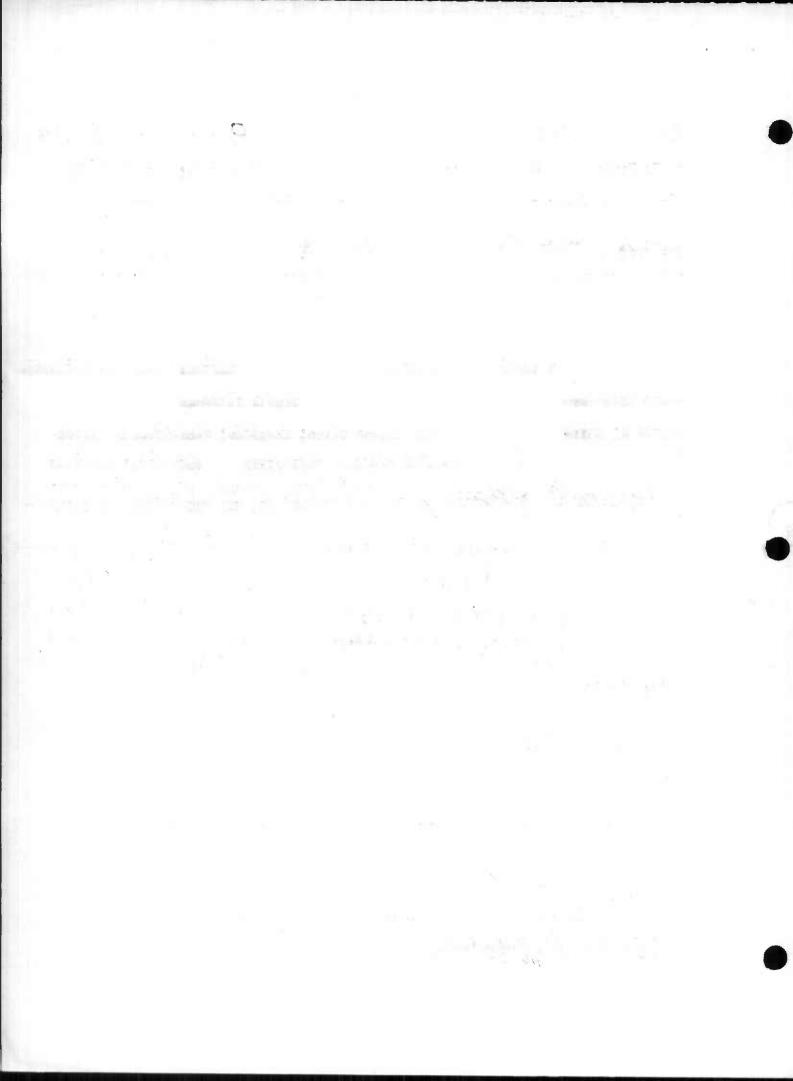
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the law in the death. Page 6 may be retained by the hospital or attending physician.

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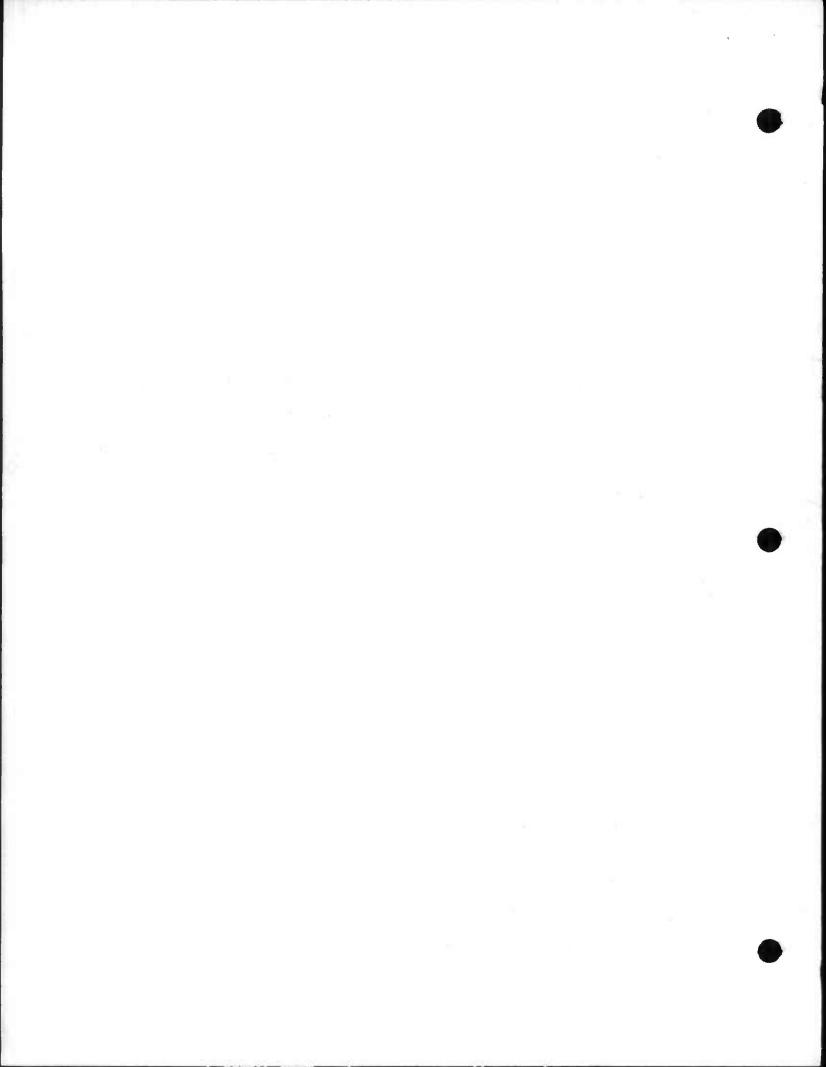
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLA	ND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL	HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Morris Kirsh.	berm				MONTH	OF DEATN	YEA 9.			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (1	76 YRS.	FUNDER 1 YEAR DAYS DAYS	IF UNDER 24 HRS. HOURS MIN. R LOCATION OF DE	7. DATE C (Month, Augu	DEBIRTN Dey, Year)	8. Bi	RTNPLACE (State or Foreign suntry) California		
TOR	Holy Cross Hospit		er Sprin			Mont	gomery				
L DIPECTOR	Maryland Mont	gomery		rown or locat	1011			10d. INSID			
FUNERAL	7420 Maple Avenue			T	20912				S.A.		
ВУ	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	If yes, sp	ENDENT OF NISPAI ecity Cuben, Mexica 2XXNO Specifi	in, Puerto R			RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	TION empleted) College (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during mo		ESS/INDUSTF					
OMP	17. FATNER'S NAME (First, Middle, Last)	Years	1	16. MOTNER'S NA				hony Orchestr			
BE C	Louis Kirshbaum		91.47		Soph	ia Fr	ciedman				
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	Leslie A. Shire 339 Joseph Drive, Kingston, Pennsylvania 18704 20s. METNOD OF DISPOSITION 1 & Burlei 2 Cremetton 3 Removal from State 4 Donatton 6 Other (Specify) 4 Donatton 6 Other (Specify) 399 Joseph Drive, Kingston, Pennsylvania 18704 20c. LOCATION - City or Town, State cometery, cremetory or other place) Menorah Gardens 10/15/1995 Rockville, Maryland										
	4 Donation 6 Other (Specify)	N	denorah Ga		10/15/1 ID ADDRESS OF FA		Roc	kville	, Maryland		
	Donald C.		myer	STEIN	HEBREW :	MEMOR			HOME, INC.		
	23. PART 1. Enter the diseases, or co shock, or heert failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications that coused at only one cause on e	ach Tine.			ch as card	lisc or respira	tory srrest,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entire UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	CO CONCY	CONSEQUENCE OF):						1075		
AL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 — YES 2 — NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
N: N	DID TOBACCO USE CONTRI	BUTE TO CAUSE C			UNCERTAI	N					
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	HOSPITAL:		OTHER:		a // out	. 10	-			
PHYSICIAN: MEDIC	27. MANNER OF DEATN 1 Netural 5 Pending	26e. OATE OF INJURY (Morith, Day, Year)	28b. TIME	OF 28c. IN.	URY AT PRK?		SCRIBE NOW INJ	URY OCCURE	D		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spe				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	and and	IAN: To the best of my know							use(s) and manner as atated,		
TO BE C	29b. SIGNATURE AND TITLE OF CONTIFIER							29d. DATE SIGNED (Month, Day, Ybar)			
-		ID. 10313	60072 A		her Spr	~	MD	2090	2		
	OCT 2 0 1995	32. REGISTRAR'S SIGN	LL		•)					



	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH MONTH DAY YEAR			3. TIME OF DEATH	1	
â	Mary	M			LETKE	ETKE			6 19	95	4:00	ам
	4. SOCIAL SECURITY NUMBER 233-30-1849	5. SEX 6. AGE (In yrs. lest birthday) 1 M 2 F HODER 1 YEAR FUNDER 24 HRS. 7. DATE (MONTHS DAYS HOURS MIN. AGE)					E OF BIRTH		. BIRTHE	ville, W.	vA.	
	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TOWN	OR LOCATION OF D			9c. COUNT			-
TOR	FRANKLIN SQUARE HOSPITAL				BALTIMOF	E COUNTY			Ba1	time	ore	
DIRECTOR	10s. STATE 10b. COUNTY Maryland Bal		10c. CIT	Perry H					- 1	10d. INSIDE CITY LIMITS?		
FUNERAL	100. STREET AND NUMBER 9900 Richlyn Dri	VA			10	f. ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?	40
NE I	11. MARITAL STATUS	12. WAS DECEDENT EV	FRINUS AR	PMED	12 WMS DE	CENOENT OF HISPA	NIC ODIO	610 /0 IA - M				
B	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 1 1	YES 2 X		If yes, s	ecity Cuben, Maxic 2 NO Speci	an, Puerto	Rican, atc.)	or No —	Black, Specify	RACE — American Indian, Black, White, atc. Specify: White	
9	16. OECEDENT'S EOUC. (Specify only highest grade of	ATION	16a. DE	ECEDENT'S	USUAL OCCUPATI	ON	10	ib. KIND OF BUS	SINESS/INDU			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life	OUSE!		osi of worlding		Homema	ker			
S S	17. FATHER'S NAME (First, Middle, Last)			-		18. MOTHER'S NA	AME (First					
BE C	Curtis W. Smith							elton	,			
2	190. INFORMANT'S NAME (Type/Print) Kenneth Letke		19	6. MAILING 9900	Richlyn	nnd Number or Rural Drive	Bal	nber, City or Town	n, Stete, Zip C , Md .	211	28	
	20a. METHDD OF DISPOSITION XIXBurial 2 □ Cremation 3 □ Remote 4 □ Donation 6 □ Other (Specify)	20b.PLACE	ACE AND DATE OF DISPOSITION (Name of Secretarion of Party of Town, Secretarion of Party Hall, M. Michael's Lutheran Cem. 10/19/95 Perry Hall, M.						m, State Mary Land	4		
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	001120	7 100 1	22. NAME A	ND ADDRESS OF FA	CILITY					-
	· bankar of	200 July			L A SSAH 7401 E	N FUNERAL ELATR ROAD	HOME BAL	, INC. TIMORE, M	MARYLANI	212	36-4625	
	23. PART I. Enter the diseases, of complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Cardiogenic shock 5 hours									tween Death		
	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate our To (OR AS A CONSEQUENCE OF):											
임	CAUSE (Disease or Injury CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):										+	
E	that initiated events reaulting in death) LAST											
	2127 # 24 - 4 - 4										_	
DICAL	Renal failure	contributing to deel	th but not r	resulting				24a. WAS AN AUTOPSY PERFORMED?		1 6	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDIC											YES 2 N	.
Ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE				UNCERTAI	N 🗆					
ğ	EXAMINER?	HOSPITAL:			TH (Check only one) OTHER:							
H	27. MANNER OF DEATH	1 1 Inputient 2 ER/		28b. TIM		URY AT	_	er (Specify) SCRIBE HOW IN	HIRY OCCU	BED.		_
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	er)	INJ		PRK?	200.0	QUIBE NOW II	WORT OCCU	NED		
COMPLETED B	3 Suicide 6 Could not be detarmined	26a. PLACE DF INJ building, atc. (URY — At ho Specify)	eme, tarm,	street, factory, offic		261. LO C/n	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
<u> </u>	29a. CERTIFIER (Check only	AN: To the best of my k	nowledne de	ath occurs	ad at the time date	and place, and due	to the ex					
S S	(Check only one) 2 MEDICAL EXAMINER										and manner as ste	ted.
	296. SIGNATURE AND TITLE OF CERTIFIER		_			29c. LICENSE NUI						
38 0	Embland X					D 476	85		Doctober 16 1995			5
2	30. NAME AND ADDRESS OF PERSON WHO Dr. Naeem Lughman:					Drive B	alti	more MI		_		
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S S	IGNATURE							-		
	DCT 2 0 1995 Jul	u divoler	Addell									



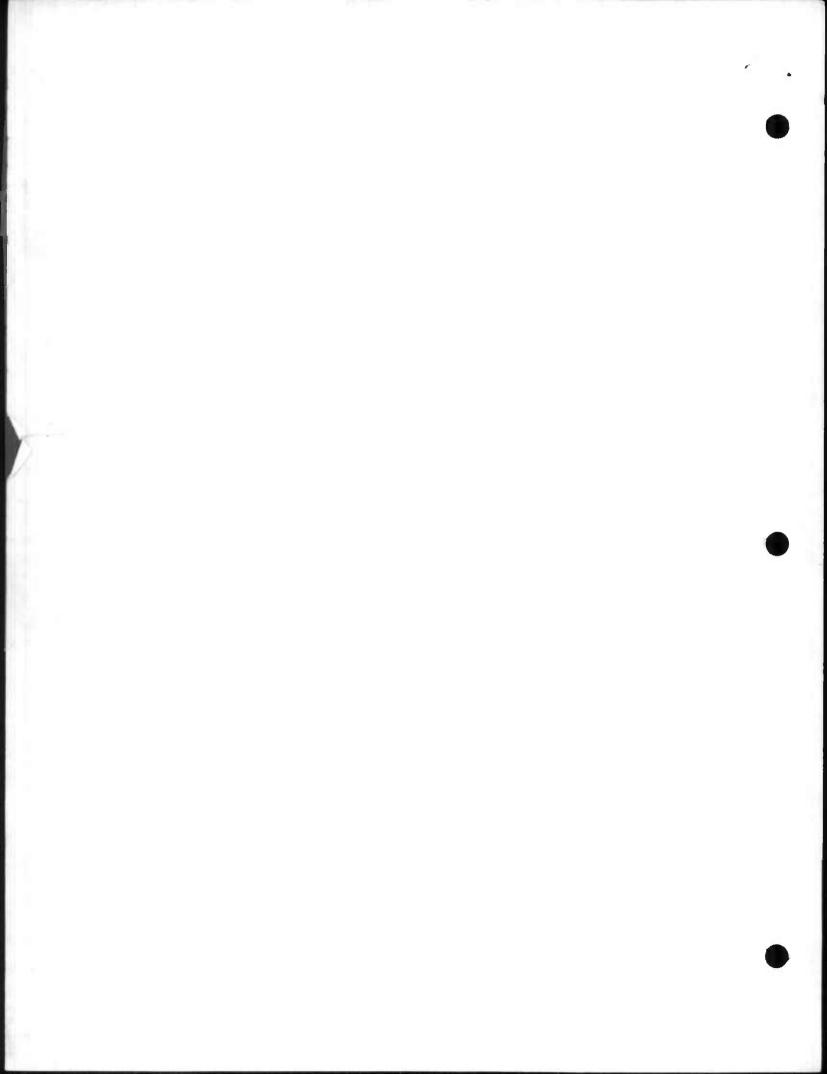
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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- 31	ERIC	MOI	RGAN		2. DATE OF DEATH	DAY YEAR 95	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 218-68-5745	5. SEX 6. AGE		UNDER 1 YEAR IF UNDER 2	MIN. 7. DATE OF BIRTH (Month, Day, Year)	Gount	HPLACE (State or Foreign					
TOR	98. FACILITY NAME (If not institution, give str MARYLAND CO RESIDENCE OF DECEDENT	RRECTIONA		HAGERS	N OF DEATH	9c. COUNTY OF I	NGTON					
DIRECTO	10e. STATE 10b. COUNTY	llA	10c. CITY, TO	Balto			10d. INSIDE CITY LIMITS? 1 1 YES 2 NO					
IERAL	5614 North	wood Dr	an.	101. ZIP CODE	12	10g. CITIZEN OF	WHAT COUNTRY?					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	3 2 K NO	If yes, specify Cuben	HISPANIC ORIGIN? (Specify 1, Mexican, Puerto Rican, etc.) Specify:	tes or No— 14. RAC Blac Spec	CE — American Indian, ck, White, etc.					
PLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	done during most of working	16b. KIND OF B	USINESS/INDUSTRY						
E COMPL	17. FATHER'S NAME (First, Middle, Last)	morgan			ER'S NAME (First, Middle, Meldle	on Surrame)						
TOB		gan	196. MAILING ADI	Northwo	-		21212					
	20e, METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	wal from State	PLACE AND DATE OF D	glocol orial Pk	18/2/95 K	ocation - city or to	stown, State					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F. H. West 4300 Wabash Ave											
	shock, or heart failure. L IMMEDIATE CAUSE (Final disease or condition	BRAIN	0,000,000,000				Onset and Death					
ALION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF):	L TUM		2010 5						
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS INTRA DUE TO (OR AS AUTO IN	A CONSEQUENCE OF): A CONSEQUENCE OF):	L TUM	NCY SYND	RomE						
N: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS IN TRA) DUE TO (OR AS AUTO IN DUE TO (OR AS as a contributing to death	A CONSEQUENCE OF): A CONSEQUENCE OF): MMUNE A CONSEQUENCE OF): but not resulting in ti	DEFECIE	Ven in Part I. 24a. WAS	IN AUTOPSY 24I						
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS IN TRA) DUE TO (OR AS AUTO IN DUE TO (OR AS as a contributing to death	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the consequence of the con	DEFECIE the underlying cause git ITIS 26. PLACE OF DE	Iven in Part I. 24a. WAS / PERF 1 YES	IN AUTOPSY 244 ORMED? 2 1 NO	B. WEEL. B. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions CRYPTOS 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DATO 27. MANNER OF DEATH 1 Netural 5 Pending	DUE TO (OR AS IN TRA) DUE TO (OR AS AUTO IN DUE TO (OR AS CONTRIBUTING TO DUE TO HOSPITAL:	A CONSEQUENCE OF): CRMMIA A CONSEQUENCE OF): MMUNE A CONSEQUENCE OF): but not resulting in the consequence of the consequenc	DEFECIE The underlying cause given in the content of the content	Ven in Part I. 24a. WAS / PERF-1 TYES ATH (Check only one) Idence 6 Prother (Specify) 28d. DESCRIBE HOV	IN AUTOPSY DRIMED? 2 INO IN FIRM	B. WEEL. B. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending	DUE TO (OR AS TNTRA DUE TO (OR AS AUTO (N) DUE TO (OR AS CONTRIBUTION OF AS CONTRIBUTION OF AS HOSPITAL:	A CONSEQUENCE OF): CRAWIA A CONSEQUENCE OF): MMUNE A CONSEQUENCE OF): but not resulting in the consequence of the consequenc	DEFECIE TO M DEFECIE THER: Nursing Home 5 Res THER: WORKY M 1 YES 2	Ven In Part I. 24a. WAS / PERF 1 YES ATH (Check only one) Idence 6 POther (Specify) 28d. DESCRIBE HOV	IN AUTOPSY DRIMED? 2 INO I N F I R W V INJURY OCCURED	8 WEEL B. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only)	DUE TO (OR AS TNTRA DUE TO (OR AS AUTO (N) DUE TO (OR AS CONTRIBUTION OF TO (OR AS CONTRIBUTION OF TO (OR AS CONTRIBUTION OF TO (OR AS CONTRIBUTION OF TO (OR AS CONTRIBUTION OF TO (OR AS DUE TO (OR AS AUTO (N) DUE TO (N) DUE TO (OR AS AUTO (N) DUE TO (N) DUE TO (OR AS AUTO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE TO (N) DUE T	A CONSEQUENCE OF): CRANIA A A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the consequence of	DEFECIE The underlying cause git IT IS 28. PLACE OF DE THER: Nursing Home 5 Rea F 28c. INJURY AT M 1 YES 2 R, factory, office	ATH (Check only one) 24a. WAS / PERF- 1 YES ATH (Check only one) 28d. DESCRIBE HOW 28f. LOCATION (Stree	IN AUTOPSY DRMED? 2 INO	B WEEK B. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,					
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ATO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suleide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE DE CERTIFIER Juna Telace	DUE TO (OR AS TNTRA DUE TO (OR AS AUTO (N DUE TO (OR AS CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS) CIAN: To the bast of my known of the basts of sxamination of the basts of	A CONSEQUENCE OF): CRANIA MA A CONSEQUENCE OF): MOUNE A CONSEQUENCE OF): but not resulting in the consequence of the consequ	DEFECIE The underlying cause git IT IS 26. PLACE OF DE THER: Nursing Home 5 Res F 28c. INJURY AT WORK? M 1 YES 2 M, factory, office t the time, deta and place, m my opinion, death occurs 29c. LICEI D -	Ven in Part I. 24a. WAS / PERF-1 YES ATH (Check only one) 28d. DESCRIBE HOV NO 28f. LOCATION (Streetly) or Yown, Streetly or Young, Streetly or Young, S	IN AUTOPSY DRIMED? 2 INO 241 IN FIR W INJURY OCCURED and Number or Rural tel and due to the cause(29d. DATE SIGNEI	B WEEK B. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH 1 YES 2 NO Route Number, (e) and manner as stated.					
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 AO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suleide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE DE CERTIFIER	DUE TO (OR AS TNTRA DUE TO (OR AS AUTO (N DUE TO (OR AS CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS B CONTRIBUTION OF TO (OR AS) CIAN: To the bast of my known of the bast of sxamination of the bast of sxamination of the bast of th	A CONSEQUENCE OF): CRAWIA A CONSEQUENCE OF): MOVE A CONSEQUENCE OF): but not resulting in the consequence of the consequence	DEFECIE TO M DEFECIE A underlying cause git IT IS 28. PLACE OF DE THER: Nursing Home 5 Res F 28c. INJURY AT WORK? M 1 YES 2 At, factory, office the time, deta and place, n my opinion, desth occurs 29c. LICEI	Ven in Part I. 24a. WAS J. PERF. 1 YES ATH (Check only one) Idence 6 Pother (Specify) 28d. DESCRIBE HOV NO 28f. LOCATION (Streecity or Yown, Streecity or Young, Stree	IN AUTOPSY DRIMED? 2 INO 241 I IV F I R W I INJURY OCCURED Internet as stated. and due to the cause 29d. DATE SIGNEI 1 O []	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AND Route Number, (e) and manner as stated.					

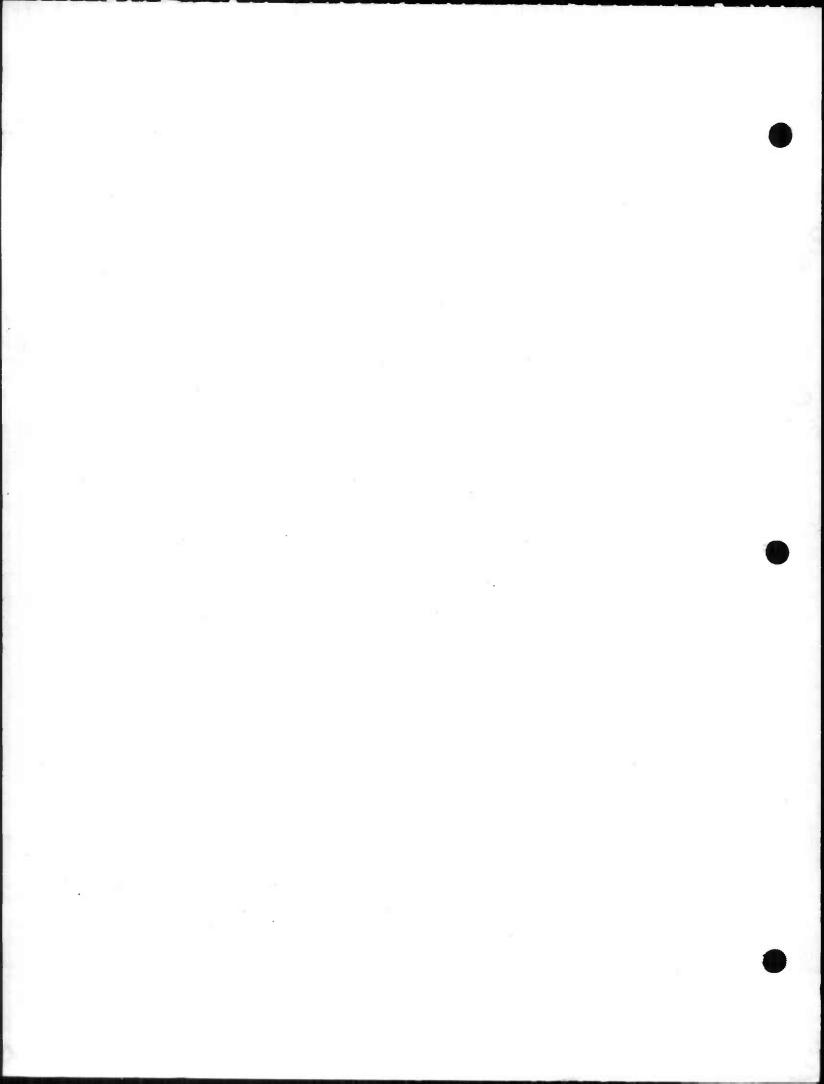
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)			2, DATE OF DEATH	V VEAR	3. TIME OF DEATH					
	EMMANUEL MOORE		10-16-95 LAOSA M								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In	R IF UNDER 24 HRS.	7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign Country) 1. Country)								
	824-14 2620 1×1 M 2 OF 83	YRS. MONTHS DAY	B HOURS MIN.	Jory 10,10	112 Virginia						
	Se. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOW	N OR LOCATION OF DE	ATH	9c. COUNTY OF	DEATH					
e e	Mendan loch Manen Care	Cnt. I	Sattimo	re	M	4					
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY /	140 OFF TOWN OR 10				10d. INSIDE CITY					
DIRECTOR	10e. STATE 10b. COUNTY	18c. CITY, TOWN OR LO	magine .			LIMITS?					
	10e. STREET AND NUMBER	130111	more		40 - OFFITEN OF	t X YES 2 NO					
FUNERAL	200 o Dell are ant	1915	101. ZIP CODE	21	tog, CITIZEN OF	10 -					
N.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A		212			Sa					
	1 Nover Married 2 Married FORCES? 1 YES 2 X	NO If yes,	specify Cuban, Mexican		Or No — 14, HA	CE — American Indian, ack, White, atc.					
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	_ ' '	res 2 NO Specify		E	Mack					
	15. DECEDENT'S EDUCATION 18a. D	ECEDENT'S USUAL OCCUP		16b, KIND OF BUS	INESS/INDUSTRY						
	(Specify only highest grade completed) (Specify only highest grade completed) (College (1-4 or 5 +)	Give kind of work done during le. Do NOT use retired.)	most of working			11)					
교	8 0	Truck Dr	iver	IrA	nspor	tation					
COMPLETED	17, FATHER'S NAME (First, Middle, Lest)		16. MOTNER'S NA	ME (First, Middle, Melden	Sumame)						
BE C	Unknown		U	nknoar		1/					
	198_INFORMANT'S NAME (Type/Print)	9b. MAILING ADDRESS (SIN	et and Number or Rural f	loute Number, City or Town	n, State, Zip Code)	1.10.6.01					
٩	longa /lore à	230 Dalla	S COUNT	, 13all	more,	MO 2123/					
		EAND DATE OF DISPOSITION remittory or other blace)	(Name of	BATE 200 10	CATION - City or	Town, State					
	□ Donation 5 □ Other (Specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	veer-tami	1 (emde	V 121/08 >1	UHOIK.	Virginia					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22 NAMI	AND ADDRESS OF FA	Russ +	ineral	Home					
	Delph L. Tuess	28	2211) 100	with are	Balto.	Md 01216					
	23. PART I. Enter the diseases, or complications that caused the d	ieath. Do not enter tha	mode of dying, suci	aa cardiac or reapi	ratory arrest,	Approximate					
	ahock, or heart failure. List only one cause on each line.										
	disease or condition Dogs: (1) of the season wines on the season wines of the season w										
	reaulting in deeth) a. 10 Volume 1 DUE TO (OR AS A CONSI	EQUENCE OF):	01	1000	100						
-	- Trackord for Respuedon Inches										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):										
EA	cause, Enter UNDERLYING	The h	earl	facili	u ·						
Ē	CAUSE (Disease or injury that initiated events	EOUENCE OF):		-/							
EH	reaulting in death) LAST										
	PART II. Other algnificant conditions contributing to death but not	resulting in the underl	vina ceuse given in	Part I. 24s. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS					
EDICAL			,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
ED				1 🗆 YES 2	XINO	OF DEATH?					
Σ	DID TORACCO LISE CONTRIBILITE TO CALISE OF DE	ATH VES TO NO	[] IINCEPTAIR			t TYES 2 NO					
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chock only one)										
S	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetiant 2 ER/Outpetlant	QTHER:									
448	27. MANNER OF DEATN 28e. DATE OF INJURY	14	INJURY AT	nca 6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED							
	1 Natural 5 Pending (Month, Day, Year)	INJURY	WORK?								
ВУ	2 Accident investigation 28e. PLACE OF INJURY — At I			28f. LOCATION (Street	and Number or Run	al Route Number,					
	Surrore B Could not be building, etc. (Specify) Momicide detarmined			City or Town, State)							
COMPLETED	29a. CERTIFIER										
MP	29s. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated.										
8											
BE	29b. SUSPATURE AND TITUE OF CERTIFIED	em	29c. LICENSE NUI	661	29d. DATE SIGN	20 95					
9	30. NAME AND ADDRESS OF PERSON WAY COMPLETED CAUSE OF DEATH (IT	FM 27) (fire Print) -	1		000	in the					
	SIREFOH TRIPURANENIS	36% The	Hugen	eda.	WA 9	11939.					
	31. DATE FILED (Month, Day, Mary)	•	100	more,	1000	100					
	OCTO (1995)	4									



	1 - STATE STATE OF MARYLAND / DEPARTMENT (CERTIFICATE		MENTAL HYGIENI REG. NO.	E							
1	1. DECEDENT'S NAME (First, Middle, Last) Romald J. Murray		2. DATE OF DEATH MONTH DA		3. TIME OF DEATN						
ļ,	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) If UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE OF BIRTH		8: 100. M						
	215-83-3109 1½ M 2 🗆 F 32 YRS. MONTHS 0	AYS HOURS MIN.	(Month, Day, Year)	Count	itimore, md						
œ		OWN OR LOCATION OF DE	ATH	9c. COUNTY OF							
5	CHURCH HOME HOSPITAL	BALTIMORE	CITY	n/a							
DIRECTOR		BALTIMORE			10d, INSIDE CITY LIMITS? 1 XYES 2 NO						
RAL	100. STREET AND NUMBER	101. ZIP CODE		10g. CITIZEN OF							
FUNERAL	1509 MONTEPELIAR STREET 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS	21218 DECENDENT OF HISPAN	IIC OBIONE (D II. V	UNITED	STATES						
B≺	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES TO	B. specify Cuben, Mexical YES 2 NO Specify	n, Puerto Rican, atc.)	Blac	E — American Indian, k, White, etc. #y: BL ACK						
回	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCU (Give kind of work done duri	IPATION ng most of working	16b. KIND OF BUS	INESS/INDUSTRY							
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) I/O. Do NOT use retired.) LABORER		VAR	IOUS J	OBS						
BE CO	JERUME BACKMUN	DAI									
2	P DAISY ARRINGTON 748 MC		NUE, BALTI		21218						
	20a_METHOD OF DISPOSITION 153 Burla! 2 Cremetton 3 Removal from State 20b.PLACE AND DATE OF DISPOSITION cemetery, cremetory or other place)		1	CATION — City or To							
	4 Denetion 8 Other (Specify) VOSHE MEMOR	KLAL GARDE ME AND ADDRESS OF FA	NS 10-20	DUNDALK,	MD						
	The of the wind	C. MARCH	FH1101	E. NORTH	AVENUE						
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, suci	h aa cardiac or reapir	ratory arreat,	Approximata intervai Between						
	IMMEDIATE CAUSE (Final disease or condition										
	disease or condition reaulting in death) a. Sepsis Due to (or as a consequence of):										
NO	Sequentially list conditions,										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING										
IF	CAUSE (Disease or Injury Last that initiated events DUE TO (OR AS A CONSEQUENCE OF):	that hibaton events									
SER	d										
CAL	PART II. Other aignificant conditions contributing to death but not resulting in the under	riying causa given in	Part i. 24s. WAS AN / PERFORI		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO						
MEDIC	Electrolyte Imbalance	. > 1	1 🗆 YES 2		COMPLETION DF CAUSE OF DEATH?						
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	DID TORACCO LISE CONTRIBILITE TO CALISE OF DEATH YES IN NO IT LINCOTTAIN IT									
PHYSICIAN:	24 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only EXAMINER?	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
YSIC	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing	Nome 5 Residence	6 Other (Specify)								
		WORK?	28d. DESCRIBE NOW IN	JURY OCCURED							
TED BY	3 Suicide 8 Could not be determined determined	office	281. LOCATION (Street of City or Town, State)	nd Number or Rural I	Route Number,						
COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, one)										
S	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opini	on, death occured at the	time, date end place, and	due to the ceuse(e	e) and menner ee stated.						
BE	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUM		29d, DATE SIGNED							
2		D 388	70	10/	15/95-						
- 1	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

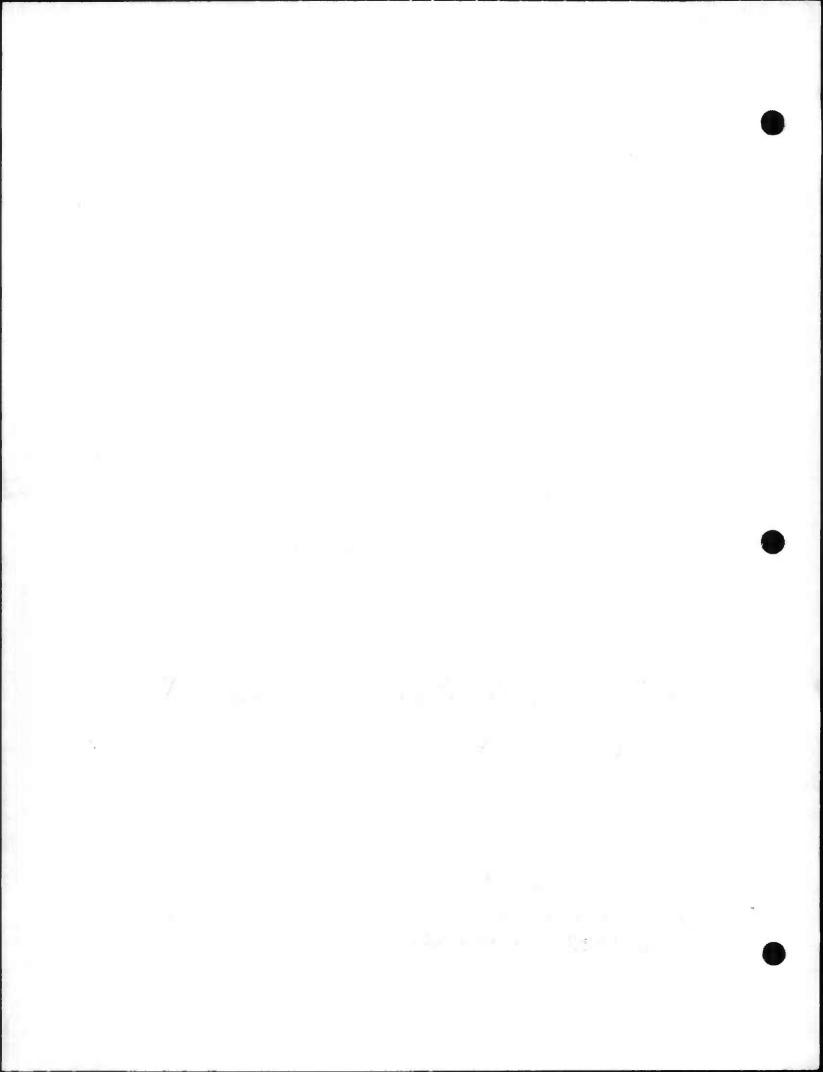
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED (Month, Day, Year)

OCT 2 01995

02. REGISTRAR'S SIGNAPURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNEFAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

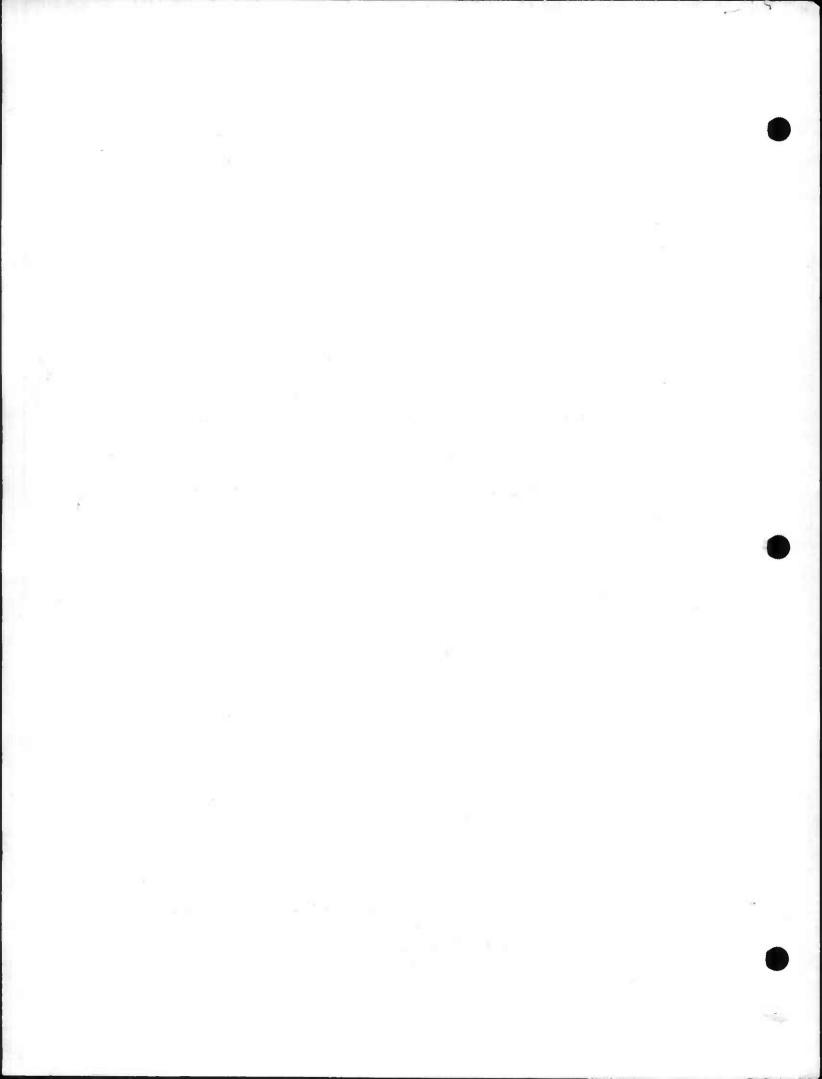
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

ITEM: 27. PER MEO FILM G-731 1/22/96 t.t

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR		IEALTH AND	MENTAL HYGIE				
	t. DECEDENT'S NAME (First, Middle, Last)		-			2. DATE OF DEATH	DATE OF DEATH 3. TIME OF DEATH			
1 8	BERNARD	D L.			MCDHFFTF			95 12:00 P.M		
3	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTNPLACE (State or Foreign Country)		
	219-66-5466 9a. FACILITY NAME (If not institution, give atre	1 M 2 □ F	35 YRS.		HOURS MIN.	MAR. 31,		Maryland		
Œ	UNIVERSITY HOSE				OR LOCATION OF D		9c. COUNTY	Y OF DEATN		
5	RESIDENCE OF DECEDENT									
DIRECTOR	Maryland N		ry, town or Local ltimore	TION			tod. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 806 N. Brice Stree	+		10	21217		17171	N OF WHAT COUNTRY?		
N.		12 WAS DECEDENT EVER IN I	II S ADMED	12 WAS DEC		NIC ORIGIN? (Specify	U.S	I. RACE — American Indian.		
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yee, ap		an, Puarto Rican, etc.)	THE OF NO.	Black, White, atc. Specify: Black		
0	15. DECEDENT'S EDUCA (Specify only highest grade or	ATION Ormoleted)	16a. DECEDENT'S	USUAL OCCUPATI	ON set of working	16b. KIND OF E	USINESS/INDUS	The state of the s		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)						
MP	10th		SALI	ES REP			rious p	laces		
	tr. Fatner's Name (First, Middle, Last) Lewis				16. MOTNER'S N.	Mac First, Middle, Malo		150		
BE	19a. INFORMANT'S NAME (Type/Print)		195 MAIL INC	C ADDRESS (Street		Mae Find		arda)		
2	Henretta Hayward							, MD 21215		
	20a, METHOD OF DISPOSITION	206.6	PLACE AND DATE	OF DISPOSITION (N	ame of			y or Town, State		
	XX Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	/ml from State	tery, crematory or o	CEMETE	RY	10-21	LANSDO	WNE, MD		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE B		22. NAME A	ND ADDRESS OF F	Home Eas	-			
	France	14ms	-	1101	E. North	Avenue/B	altimor	e, MD 21202		
	23. PART I. Enter the diseases, or co	inplications that caused	the death. Do	not enter the me	oda of dying, au	ch as cardiac or re	apiratory arres	Approximate		
	IMMEDIATE CAUSE (Final							Onset and Death		
	disease or condition Intra-Grebral Hemorrhage									
	disease or condition . Intra-Grebral Hemorrhay. Due to (or as a consequence of): Hypertensive Cardio vascular Disease.									
NOI	DIJE TO TO AS A CONSEQUENCE OF									
CAT	If any, leading to immediata cause. Enter UNDERLYING									
E	thet initiated events	DUE TO (OR AS A	CONSEQUENCE O	OF):						
CERTIFICATION	resulting in deeth) LAST									
AL C	PART ii. Other significant conditions	contributing to deeth bu	it not resulting	In the underlyin	g cause given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
SC							PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDIC								1 PYES 2 NO		
ž	DID TOBACCO USE CONTR		and the same of th			N□				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ATN (Check only one OTHER:						
YSI		HOSPITAL: XXInpatient 2 ER/Outpa		4 - Nursing Hor		6 Other (Specify)				
	27. MANNER OF DEATN 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. Till	JURY W	JURY AT DRK? YES 2 NO	28d. DESCRIBE HO	W INJURY OCCU	RED		
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY -	- At home, larm,			281. LOCATION (Stre	et and Number or	Rural Route Number,		
Ë	4 Homicide determined	building, atc. (Specif	(Y)			City or Town, Sta	ite)			
COMPLETED		IAN: To the best of my knowle						cause(a) and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	0 00			29c. LICENSE NU			SIGNED (Month, Day, Year)		
) BE	Clernin	J. Chute n	Q.		O.C.M	. E .	ОСТОЕ	BER 16, 1995		
2	DENNIS CHUTE	COMPLETED CAUSE OF DEA						yland 21201		
	3t. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA								
	OCT 2 0 1995	To Mudlande	al M							

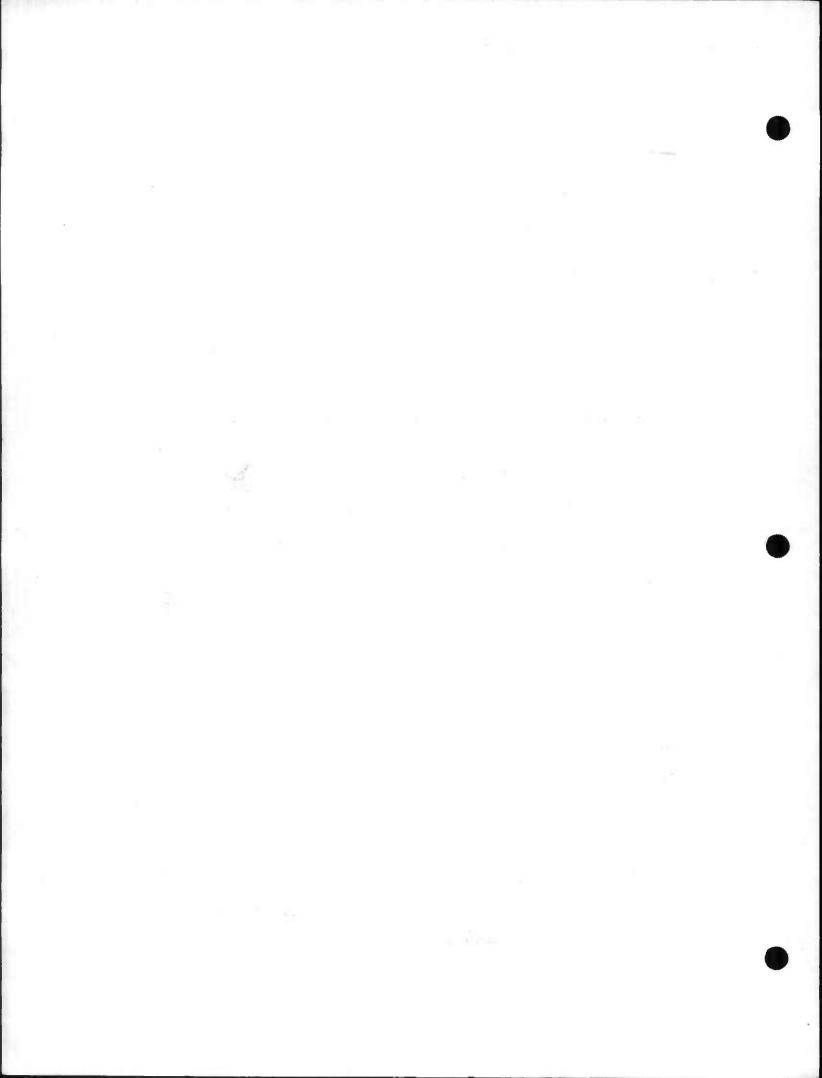


BALTIMORE, MARYLAND 21215-0020

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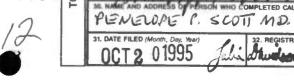
	1 - STATE REGISTRAR		SIAIL OF I	VIANT LA				DEAT		REG. N				
1	MONTH DAY YEAR								3. TIME OF DE					
181	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In)			AIITE yrs. last birthd		IR 1 YEAR	IF UNDER	24 HRS.	OCT. 17, 1995			2:45		
	₁₈₁ 180 -30-023	32	1 💢 M 2 🗌 F		8 YR	MONTHS	DAYS	ночна	MIN.	July 15,	1937	Country	nsylva	
	9a. FACILITY NAME (# not in		reet and number)			9b. CI1	Y, TOWN	OR LOCATIO	N OF DE		_	NTY OF DE		11110
СТОВ	78 GEORGE					G	EOR	GETOV	IN		C	ecil		
111	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY			10c.	CITY, TOWN	OR LOCA	ATION					10d. INSIDE C	TY	
DIR	Pa.	Che	ester		C	oates	vill	.e					LIMITS?	
FUNERAL	100. STREET AND NUMBER	jazers	Rd.				10	01. ZIP CODE	320		10g. CIT		HAT COUNTRY	
B⊀	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 XXXDivo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 XNO	ts	If yes, s		n, Mexica	IIC ORIGIN? (Specify n, Puerto Rican, etc.)	Yes or No—		- American in White, atc.	
PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			+)	(Give kind	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Lumbe						DUSTRY		
COMPL	17. FATHER'S NAME (First, M	iddle, Last)			00100			18. MOTH	IER'S NAI	ME (First, Middle, Maid				
ш	John E. M	latthev	IS					A	lice	e Perrine				4
TO B	John E. Mat		TTT		1					Route Number, City or 1 Coatesv:			19320	
	20a, METHOD OF DISPOSIT	ION		20b.					nu.,					
	20b. PLACE AND DATE OF DISPOSITION 1 Burlel 2 Cycremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Company Companion of Other (Specify) 10/20 Baltimore, Md.													
	22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc.													
	1 Carrie	= 3	4.	7/10	L	5	695	Main	St.,	, Elkridg	e. Md.	21	227	inc.
CERTIFICATION	IMMEDIATE CAUSE (Fir disease or condition resulting in deeth) Sequentially list condit if any, leeding to immecause. Enter UNDERLY, CAUSE (Disease or Injuthat Initiated events resulting in death) LAS	lone, diate ING	DUE TO DUE TO	O (OR AS A	CONSEQUENC	: 0F): : 0F):	MOI	mha	ge	, right		4		and Death
	PART II. Other eignifice	nt condition	e contributing to	deeth be	ut not resulti	ng in the	underiyi	ng cause g	given in	Pert I. 24s. WAS	AN AUTOPSY	24b.	WERE AUTOPS	
AN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN UNCERTAIN AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									F CAUSE				
SICIAN:	25. WAS CASE REFERRED T EXAMINER? XXVES 2 \(\square\) NO	O MEDICAL	HOSPITAL:			ОТН	ER:			6 (Specify)	ONI (~ A T T	DO ME	
BY PHYS	27. MANNER OF DEATH	Pending Investigation	28a. DATE OF			TIME OF INJURY	28c. IN	JURY AT /ORK?		28d. DESCRIBE HO			BOAT	
ED	2 - 0.1111	Could not be determined	28a. PLACE (building	OF INJURY i, etc. (Spec	— At home, fa	m, street, fo	ectory, off	lca		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
O BE COMPLETED BY PHYSICIAN: MED	onel only									to the cause(a) end time, data and place,) and manner s	a stated.
TO BE (290. SIGNATURE AND TITLE	V	Golle		97.]				C.M.		29d. DA		(Month, Day, Ye 18, 1	995
_	30. NAME AND ADDRESS OF	- G0	LIG JR	- W	₽ 111		n Si	treet	., E	Baltimor	e, Ma	aryl	and 2	1201
	OCT 2 019	35 /2	di di HEGISTR	AR'S SIGN	LA									

DIVISION OF VITAL RECORDS, P.O. BOX 6876

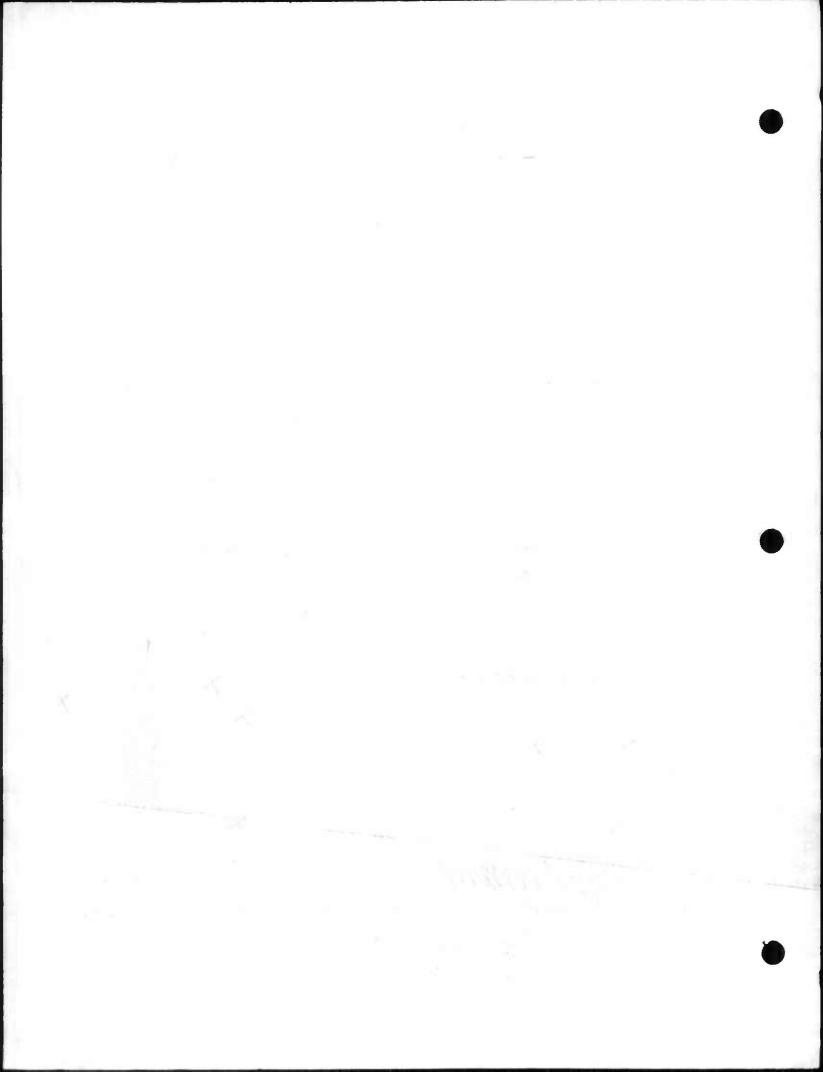


	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	requ	eeu	6	sho
	MP	as b	Dept.	23
	The	ate h	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tem t
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	10-27-93 F	11mG/20 W.	H.Per	r/H						(15	31487
	1 - FOR STATE REGISTRAR	STATE OF MAR				F HEALTH			GIEN		7 ()	01401
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF D				3. TIME OF DEATN
	MYRNA MA	GALOTTI						OCTUBE	re i		1495	12-20 1 11
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. last	birthday)	IF UNDER 1 Y	-		7. DATE OF BI	RTN		B. BIRTNI	PLACE (State or Foreign
	200-28-6083	1.51.11 2 X F	84	YRS.	MONTHS D	AYS HOURS	Mere.	May 1		11	Country	Virginia
	9a. FACILITY NAME (If not institution, give stre	et and number)			96. CITY, TO	WN OR LOCATI	ON OF DE				UNTY OF DE	
CTOR	Church Home Hospi	tal		Baltimore								
DIRECTOR	Maryland n/a				y, TOWN OR I					10d. INSIDE CITY LIMITS? 1 St YES 2 NO		
	10e. STREET AND NUMBER					101. ZIP COD	F		_	10a CI	TIZEN OF W	HAT COUNTRY?
FUNERAL	6009 Eastern Pkwy	,				2120						THAT COUNTRY?
N.	+	12. WAS DECEDENT EVE	DINILIC ADM	ien.	T 40 140						S.A.	
BY FL	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES, GIVE WAR OF	ES 2 NO)	If ye	s, specify Cubs	n, Mexico	IIC ORIGIN? (Spi n, Puarto Rican, r:	etc.)	or No—	Specif	
	15. DECEDENT'S EDUCA	TION	46- DE0	CDCNTIO	1						Whi	te
1	(Specify only highest grade co	ompleted)	(Giv	w kind of s	USUAL OCCU work done during se retired.)	PATION ng most of workir	g	16b. KIND	OF BUS	INESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)			ou rouned.)			334.4				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	4 yrs	INC	ırse					ici			
						18. MOTI	NER'S NA	ME (First, Middle,	Maiden :	Sumame)		
BE	Harry Melvin Sla	agle					tta_			illi		
2	19a. INFORMANT'S NAME (Type/Print)							Route Number, Cit			ip Code)	
-	Harry K. Magalott	<u>i</u>	14	607	Manor	Rd. Pl	noen:	ix, Md.	21:	131		
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remov		20b. PLACE AP			N (Name of		DATE	20c. LO	CATION -	- City or Tov	wn, State
	4 Donation 5 Other (Specify)		morela Morela	and 1	Memori	al Park	<	10-20	Rali	himo	re N	ы
1	21. SIGNATURE OF FUNERAL SERVICE LICEI	NSEE			22. NAI	E AND ADDRES	SS OF FAC	CILITY			100	
. 1	1	///	111		Ru	ck Tows	son I	Funeral	Har	ne.	Inc.	
_	000000000000000000000000000000000000000	1/6/	//		10	50 York	Rd	Funeral Towso	n, l	vd.	21204	
	23. PART i. Enter the diseeses, or co- shock, or haert fallure. Li	mplications that cause or st only one cause or	sed the dee n each line.	th. Do r	ot enter the	moda of dyl	ng, aucl	h as cardiac o	r reapii	ratory a	rreat,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition											Onset and Death
	resulting in death)	APULT ADULTO (OR A	LESPY	MI	MT D	SMES	5 5	YNDM	ME			
- 1												
ERTIFICATION	Sequentially list conditions, b.	GASMIZ DUE TO (OR A	ASPI	20	DUN							
F	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (ON A	S A CONSECU	JENCE OF	-):							
일	CAUSE (Disease or Injury C.	DUE TO (OR A	0 1 00110701									
E	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQU	JENCE OF	-):							
	d.											
2	PART II. Other significant conditions	contributing to deat	h but not re	sulting i	in the under	fying cause o	ilven In	Part I 24a I	MAC AN	AUTOPSY	1 245	WERE AUTOPSY FINDINGS
5	SEPSIS; CAMLI	WIMA EX	COPHA	-6-11	<	,,,	,		PERFOR			AMAILABLE PRIOR TO
0	30.0.0	,	7 7 17 1	Un.				— ') *	YES 2	□ NO		COMPLETION OF CAUSE DF DEATH?
Σ								× 1				1 TES 2 NO
Z	DID TOBACCO USE CONTRI	BUTE TO CAUSE					ERTAIN	1 🔀				,
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	N (Check only	one)						
S		Inpatient 2 ER/O	Outpatient 3	DOA	OTHER:	Home 5 🗆 Ra	sidence	8 Other (Spec	iffy)			
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year		28b. TIM	E OF 280 URY	: INJURY AT WORK?		28d. DESCRIBE	HOW IN	JURY OC	CURED	
ВУ	1 Netural 5 Pending 2 Accident Investigation	1,000,000				YES 2	NO					
	3 Suicide 6 Could not be	28a. PLACE OF INJU	JRY — At hom	e, farm, s	treet, factory,	office		28f. LOCATION	(Street as	nd Numbe	or or Rural Ro	oute Number,
TED	4 Homicide determined	building, atc. (S	spoully)					City or Town	1, State)			
۳	29a. CERTIFIER CERTIFYING PAYOR	AN: To the heat of my be								nivo de		
MP		AN: To the best of my kn										
COMPLET	2 MEDICAL EXAMINER:	OIL THE DESIG OF EXERNING	mort and/or In	restrigation	n, in my opini	on, death occur	ed at the t	time, data and p	laca, and	dua to 1	he cause(a)	and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIED	MANDON	20				NSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)
0 8	(mm/mm//)	WOOD	P			DI	513	35		► U	CT.	6, 1995
2	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF	DEATH (ITEM	27) (Type,	Print)							
	PENEROPE P. SCO	II MD.	100 V	1.13/	WADL	VM B	MI	MUNE	, N	D	217	231
- 1		_							_			



32. REGISTRAR'S SIGNATURE



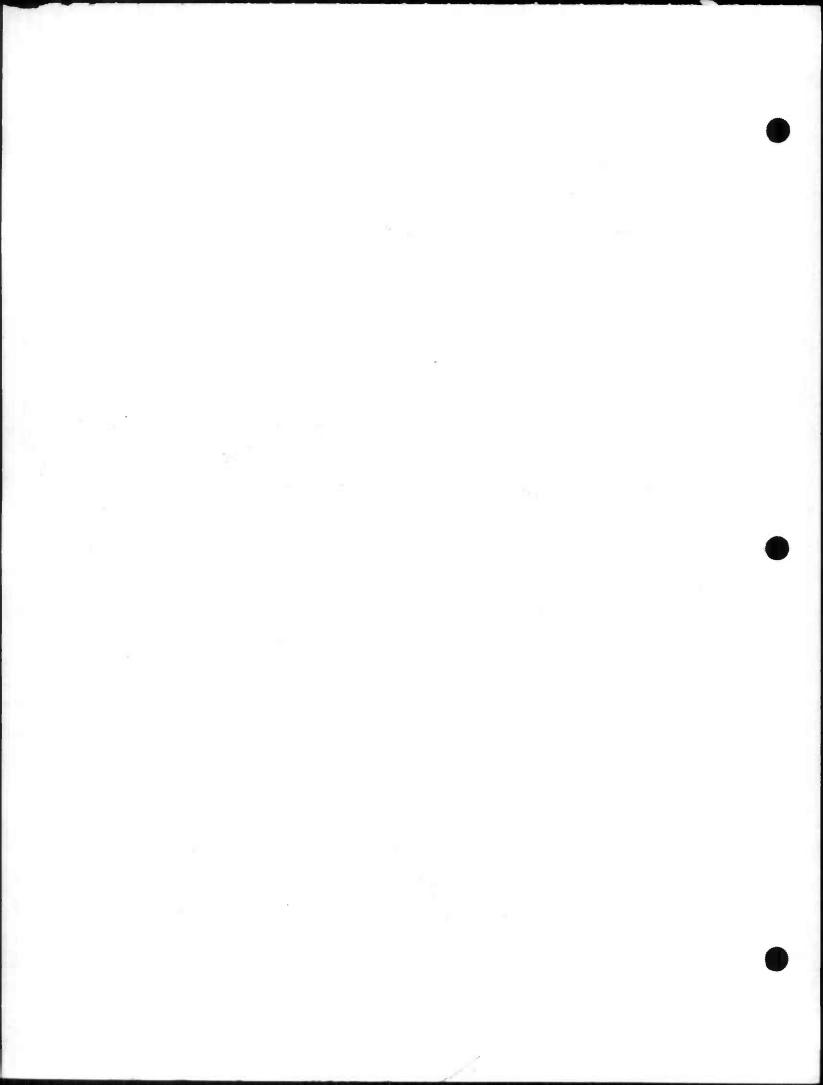
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAI		MENT OF HEALT		ENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Lest)					. DATE OF DEATN		3. TIME OF DEATH
	Clarence	May	nor			october 17	7, 1995	7:30 P M
			yrs. lest birthday) #		DER 24 HRS.	DATE OF BIRTH	8. Bif	RTNPLACE (State or Foreign
	263-05-5269 1 9a. FACILITY NAME (If not institution, give atree	M 2 □ F 84	YRS.	A. CITY, TOWN OR LOCA	Ja	enuary 11	191 F	lorida
FUNERAL DIRECTOR	5416 Addington			altimore			SC. COUNTY OF	DEATH
띮	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, T	OWN OR LOCATION				10d. INSIDE CITY
E I	Maryland		Balt:	imore				LIMITS?
100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT								
5416 Addington Road 21229 USA								
S		2. WAS DECEDENT EVER IN U	S. ARMED			ORIGIN? (Specify Yes		ACE — American Indian, lack, Whits, stc.
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATE		t YES 2 N		Puerto Ricen, etc.)	1	pecify.
	15. DECEDENT'S EDUCAT	108	- DECEDENTIA HA	A COOLINATION		1		Black
COMPLETED	(Specify only highest grade cor	npleted)	6a. DECEDENT'S US (Give kind of work life. Do NOT use re	done during most of wo	rking	16b. KIND OF BUS	INESS/INDUSTR	9/1
PLE	12th Grade	College (1-4 or 5+)		ion Work	er	City Of	Cora	les Gable
OM	17. FATNER'S NAME (First, Middle, Last)					(First, Middle, Maiden		
BE C	N/A			Ge	orgia			
	19a. INFORMANT'S NAME (Type/Print)		196. MAJLING AD	DRESS (Street and Num	ber or Rural Roo	ite Number, City or Town	n, State, Zip Code)	
2	Clifford W. Mayr	ior	5416	Addingto	n Roa	d Balt.	Md. 2	1229
	20a. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Remove		LACE AND DATE OF I	DISPOSITION (Name of		DATE 20c. LOC	CATION - City or	Town, State
	4 Donetion 5 Other (Specify)	Ur	nion Cer	meterv	/	21/95 Oca	ala, F	lorida
	21. SIGNATURE OF FUNCHAL SERVICES LICEN	HE /	?			alls Park		Homes, Inc.
	Kosielin	much				ryland 2		
	23. PART I. Enter the diseases, or con ahock, or heart failure. Lis							Approximata
	IMMEDIATE CAUSE (Final	t billy bila cadaa oii aac	ii iine.	1				Interval Between Onset and Death
	disease or condition resulting in death)	Skpati.	c foul	un				dell
		DUE TO (OR AS A C	ONSEQUENCE OF):	, ,	111 1	11	2	60
Z	Sequentially list conditions, b.	Hepothe		tases/	unk	mm /		0 mg
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):	,				
5	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A C	ONSEQUENCE OF):					
E	resulting in death) LAST							
ÄL	PART II. Other significant conditions of	ontributing to death but	not reaulting in	the underlying ceus	e givan in Pi	ert I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă						1 YES Z	X] NO	OF DEATH?
M	DID TODA CCO LICE CONTROL	NITE TO CALLER OF	DEATH VEC		I CERTAIN I	-		1 TES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE		DEATH YES		NCERTAIN	KI		
S	EXAMINER?	IOSPITAL:	- 0	THER:		_ × - × - × - ×		
7	27, MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME C	Nursing Nome 5 X		Other (Specify)	NUMBY OCCUBER	
	Netural 5 Pending	(Month, Day, Year)	INJUR	WORK?				
ВУ	2 Accident Investigation 3 Suicida 8 Could not be	28e. PLACE OF INJURY -	- At home, farm, atre			181. LOCATION (Street a	and Number or Ru	ral Route Number,
TED	4 Nomicide datarmined	building, atc. (Specify)			City or Town, State)		
COMPLET	29a. CERTIFIER CERTIFYING PHYSICIA	N: To the best of my knowled	foe death occurred	of the time, data and pis	ece, and due to	the cause(s) and man	ner sa stated	
M		On the basis of exemination s						se(e) and manner as stated.
	29b. SIGNATURE AND TYPLE OF CERTIFIER	A and A		29c, L	ICENSE NUMB	ER	25d. DATE SIGN	ED phioses, (flag. Was)
BE	alm Cas	aluful 2	110	1	24:	56	D 10	119/95
2	30. NAME AND ADDRESS OF PERSON WHO	OWELEDAD CHUSE OF DEAT	N (ITEM 27) (Type, Pr	(m) /		gor Co	for	Acres
	31. DATE FILED (Month, Day, Year)	32, REGISTRAR'S SIGNAY	Cont.	100 1140	7 /	100 00	7-1-	100
	OCT 2 01995	Studeor Rent	M			Bult	med	21229



6:40

8. BIRTHPLACE (State or Foreign

Pennsylvania

14. RACE — American Indian, Black, White, atc.

10d. INSIDE CITY

1 YES 2 XNO

9c. COUNTY OF DEATH

Baltimore

U.S.A.

Golden

10g. CITIZEN OF WHAT COUNTRY?

White

PM

REG. NO. 2. DATE OF DEATH

October 16 1995

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DIVISION OF VITAL RECORDS, P.O. BOX

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARY ANN NEMEC

7. DATE OF BIRTH (Month, Day, Year) Oct. 28,1937 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 XF 212-36-1251 burial-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 908 Dogwood Hill Ct. Towson RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Towson FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 908 Dogwood Hill Ct. 21286 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuber, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, OIVE WAR OR DATES 1 TES 2 NO BY 3 Widowed 4 Divorced the 16e. DECEDENT'S USUAL OCCUPATION

Work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ŏ 12 yrs Housewife Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Te should be Jervis Desmond Grace ш notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Nemec 908 Dogwood Hill Ct. Towson, Md. 21286 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20a. METHOD OF DISPOSITION

1 Serial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) must 10-20 Timonium, Md Dulaney Valley examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. 6 IMMEDIATE CAUSE (Fine) ung Cauxor cremation, the disease or condition Metastatic OUE TO (OR AS A CONSEQUENCE OF): event. resulting in death) burial. traumatic and Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 2 the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? апу n. of Heah shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN U Dept. PHYSICIAN: OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate han the State D OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA o the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED After this ce seath with ti marked, 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO After death BY 28e. PLACE OF INJURY — At home, term, atreat, factory, office building, atc. (Specify) 3 Sulcide 6 Could not be determined DIRECTOR: A hours after d .00 COMPLETED 4 🗌 Homicide 29a. CERTIFIER
(Check only one)

One)

MEDICAL EXAMINED. On the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and memory as stated. FUNERAL I within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 015546

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)

22. PEGISTI AR'S SU

Dr. Charles A, Padgett 5601 Loch Raven Blvd. Baltimore, Md.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> 20c. LOCATION - City or Town, State Approximata interval Between Onset and Death 4 men 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year)
>
> Oct 18, 1995 DHMH-16 Rev 1/89

- 20° 8

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

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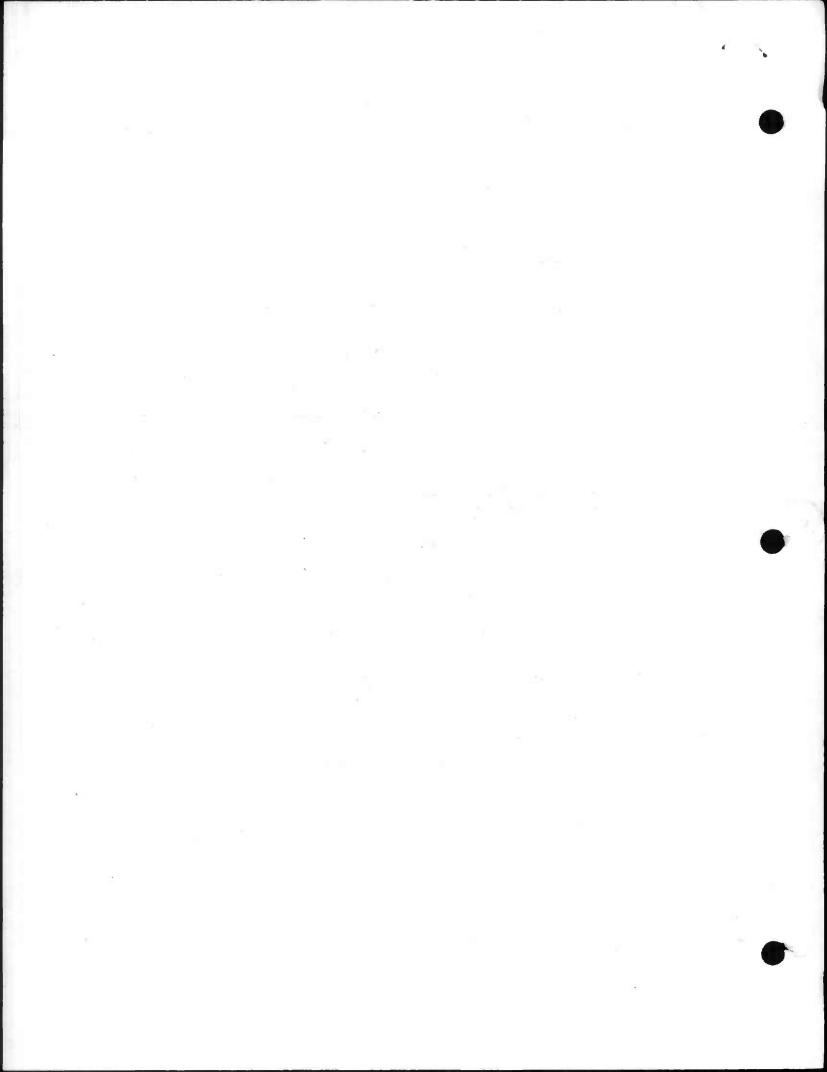
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										OF	n /"	-110	
	Items10e,19b 10	-30-95 F	ilmG728	W.H.	Per 1	F/H				9 3) 1	149	U
	1 - FOR STATE REGISTRAR	STATE OF N					EALTH AND		YGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)	NAM						2, DATE OF MONTH	, DA	NA .	YEAR	3. TIME OF	
	4.50	5. SEX	6. AGE (In yrs. la:	st birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DATE OF	HRTH	1	995	PLACE (State	40 A M
		1 🗌 M 2 🔯 F	80	YRS.	MONTHS	DAYS	HOURS MIN.	Aug.		915	Count	w Kore	
OR	9a. FACILITY NAME (If not institution, give stre Howard County Gene			9b. CITY,		olumbia				HOV			
ECT	Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard County General Hospital Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard Howard Columbia Howard										10d. INSIDE	CITY	
	-	Howard			Ell:	icot	ct City					1 YES	
FUNERAL	8456 Rolling Ridg	h Court				101.	ZIP CODE	043		10g. CIT		WHAT COUNTR	177
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X		11	yes, spe	ENDENT OF HISPAI acity Cuban, Maxica 2 NO Specifi	in, Puerto Ricai	pecify Yee n, etc.}	or No—	14. RACI Blaci Speci	E — American k, White, etc.	
밀	15. DECEDENT'S EDUCA (Specify only highest grade or		(G	iive kind of v	USUAL OCC	CUPATIO	IN st of working	16b, KIN	D OF BUS	INESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 a	- ide	. Do NOT us	e retired.) emake:					n Hor	ne		
BE CO	17. FATHER'S NAME (First, Middle, Lest) Myung Ho Kim						18. MOTHER'S NA Unknown	ME (First, Middl	le, Meiden	Surname)			
TO B	190. INFORMANT'S NAME (Type/Print) Young Chul Kim (So	on-In-La	w) 8	b. mailing 456 F	AOORESS	ng I	Ridge Coach Co	oute Number, (urt El.	City or Town	tt C	ity,	2104 Aaryla	3 nd
	20a. METHOD OF DISPOSITION 13/2 Burlel 2 Cremation 3 Ramov 4 Donetion 6 Other (Specify)	rai Irom State	20b. PLACE	AND DATE (of DISPOSIT	OC OC	et. 21,		20c. LO	CATION -	City or To	wn, State	
	21. SIGNATURE OF JUNETIAL SERVICE LICE	NSEE	Meado	wride	22. N	ME AN	D ADDRESS OF FA	CILITY				land	
Ш	K Cia, U	Vitte	-/		550	55 7	M & Rusa Win Kno	lls Ro	on be	Juml	oia.N		
	23. PART I. Entar the disesses, or co shock, or haart fallure. Li	mplications that st only one cau	caused the de	ath. Do n	ot enter t	ha mod	de of dylng, suc	h se cerdiac	or respli	ratory sr	rest,	Appro	ximsts al Between
	IMMEDIATE CAUSE (Finsi disesse or condition		He	AR	T	BLI	rec						and Death
	resulting in death) s.	OUE TO	(OR AS A CONSE									7	lays
TIFICATION	Sequentially list conditions, if any, leading to immadiate	OUE TO	(OR AS A CONSE	DUENCE OF	April 1	R	RIDRY	DIS	EAT-	E		2-3	years
길	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSE										
CERT	resulting in death) LAST			HA	PAT	IT	is					1 we	eek
	PART II. Other significant conditions						cause given in	Part I. 24s	. WAS AN		24b.	WERE AUTOPS	OT ROIF
MEDICAL	AVRTIC V	ALVE ALVE	RIPI	AR	nen	T		- 10	YES 2	NO		OF DEATH?	47
2	DID TOBACCO USE CONTRI						UNCERTAIN	NZ				1 TYES 2	□ NO
SICIA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 Inpution 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28. OATE CHINDLERY (Month, Day, Voer) 28. INJURY AT WORK?												
TY Victorial 5 Pending M 1 YES 2 NO													
ETED	3 Suicide 6 Could not be 4 Homicide datarmined	building,	etc. (Specify)	me, farm, s	treet, factor	y, offics		281. LOCATIO City or To	N (Street a: wn, State)	nd Number	r or Rural F	loute Number,	
COMPLE	29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICI.												
E CO	2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	On the Death Of 8)		veatigatio	n, m my opi	men, de	29c. LICENSE NUR		place, end				
0 86	her is	- ca	reli	4			128	921		>	0	Cliq +	# 1995
	36 NAME AND ADDRESS OF DESCON WHO	COMPLETED CALL	E OF OFATH	10 and 17									

RIPO & ROAD HICKORY 10792

Chowdhry, Imtiaz M.D. 31. DATE FILED (Month, Day, Year)

Columbia, MD 21044

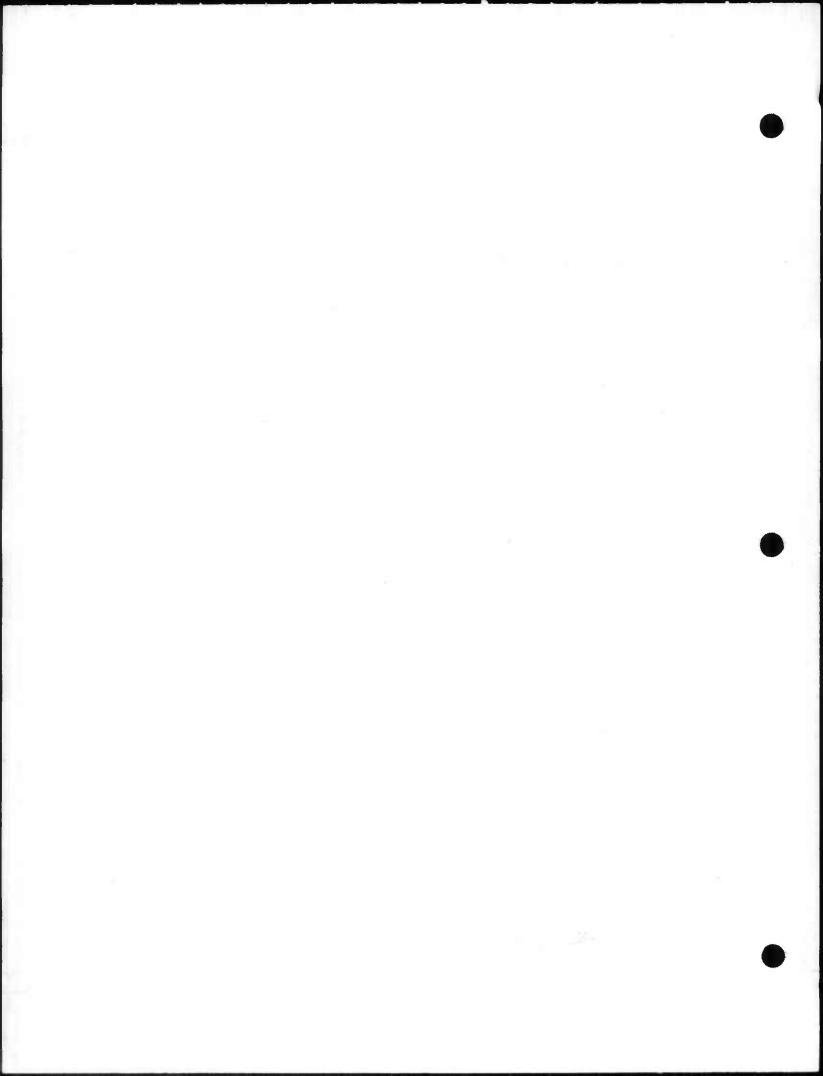


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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	IRMA		DEMUS				0. 1995	11:10 AM
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Cour	HPLACE (State or Foreign http)
	9a. FACILITY NAME (If not institution, give:	,	79 YRS.			Feb., 06,1	916 Ma	
Œ	Frederick Memoria			96. CITY, TOWN OF Freder	R LOCATION OF DE	EATH	9c. COUNTY OF	erick
DIRECTOR	RESIDENCE OF DECEDENT	it hospital		Treater	. Cic		17000	
E	10a. STATE 10b. COUNT			Y, TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland Fred	erick	f /	ederick				XX YES 2 NO
RA	750 Carroll Parkw	au-Ant 5R		101	21701		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13, WAS DEC		IIC ORIGIN? (Specify Yes		CE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO		cify Cuban, Mexican	n, Puerto Rican, etc.)	ðia.	ck, White, etc.
Э ВУ	3 Wildowed 4 Divorced				- X		1	WILLE
E	t5. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of vi life. Do NOT us	USUAL OCCUPATIO	N at of working	166. KIND OF BUS		0
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5+)	Reception	•		Keeny Vo	isford F	uneral Home
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Maiden	Sumame)	
BE C	William David Swe	adner			Grace 1		,	
0		(daughter)	19b. MAILING	ADDRESS (Street as	nd Number or Rural R	Soute Number, City or Town	n, State, Zip Code)	01701
-	Barbara Moffatt					erick, Mary	jxana	21701
	1 Burial 2 Cremation 3 Ram 4 Donation 8 Other (Specify)		netery, crematory or of		ma of	OATE 20c. LO	CATION — City or	lown, Stata
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEED ON ald Was	do Din.	22. NAME AN	D ADDRESS OF FAC	CILITY		
	Brand B	and the	1					imore Street
	23. PART I Enter the diseases, or	complications that cause	the death Do o	Km. BUZ	6-Baccan	nore, Mary	cana 21	
	snock, or neart religie.	List only one ceuse on a	ech line.	ot enter the mot	se or dying, auch	ss cardiac or reapil	ratory arrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition	Sha	60					Onset and Death
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):				Tweek
Z	Sequentially list conditions,	. Hupe	tens	By				loyears
¥	If any, leeding to immediate cause, Enter UNDERLYING	DUE TO OR AS A	COMSEQUENCE OF):				
윤	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS /	CONSEQUENCE OF	1:				
CERTIFICATION	resulting in death) LAST	d						
	PART II. Other significant condition	a contributing to death h	urt and monitor a l					
CAL	Trait is other significant condition	- contributing to death b	rut not resulting i	n the underlying	ceuse given in i	Part I. 24s. WAS AN PERFOR		MAILABLE PRIOR TO
MEDIC						1 YES 2	™	OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO F	HNCERTAIN	īn		1 NES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		OTTOEKI74II	, ,		
YSIC	1 YES 2 MO	HOSPITAL: 1 In impatient 2 ER/Outp	patient 3 DOA	OTHER: 4 Nursing Home	5 Residence	8 Other (Specify)		
F	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME			28d. DESCRIBE HOW IN	JURY OCCURED	
B	2 Accident Investigation				ES 2 NO			
9	3 Suicide 8 Could not be 4 Homicide datarminad	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, si	treet, factory, offica		28f. LOCATION (Street as City or Town, State)	nd Number or Rural	Route Number,
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYS	ICIANI, To the best of an i			Victoria de la constante de la constante de la constante de la constante de la constante de la constante de la			
MW	(Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my know IR: On the basis of exemination	ledge, death occurre n and/or investigation	d at the time, date i	and place, and due t eth occured at the t	to the cause(s) and man	ner as stated.	
	296. SIGNATURE AND TITLE OF ENHTHRIES		7.		29c. LICENSE NUM			
9 BE	116 V1	Le solito	t n	D	1) 3	5183	DATE SIGNE	(Morth, Day, Year)
۵	30. NAME AND ADDRESS OF PURSON WY	S COMPLETED CAUSE OF DE	ATH (ITEM 27) (%pe.	Print	-	1/0/		11173
	Ali J. AFron	ctel 300	w 91	454	Fred	Perick,	MD	21701
	" OCT 2 0 1906	Jahrengernay's sign	CYUNE.					
\Box			2000					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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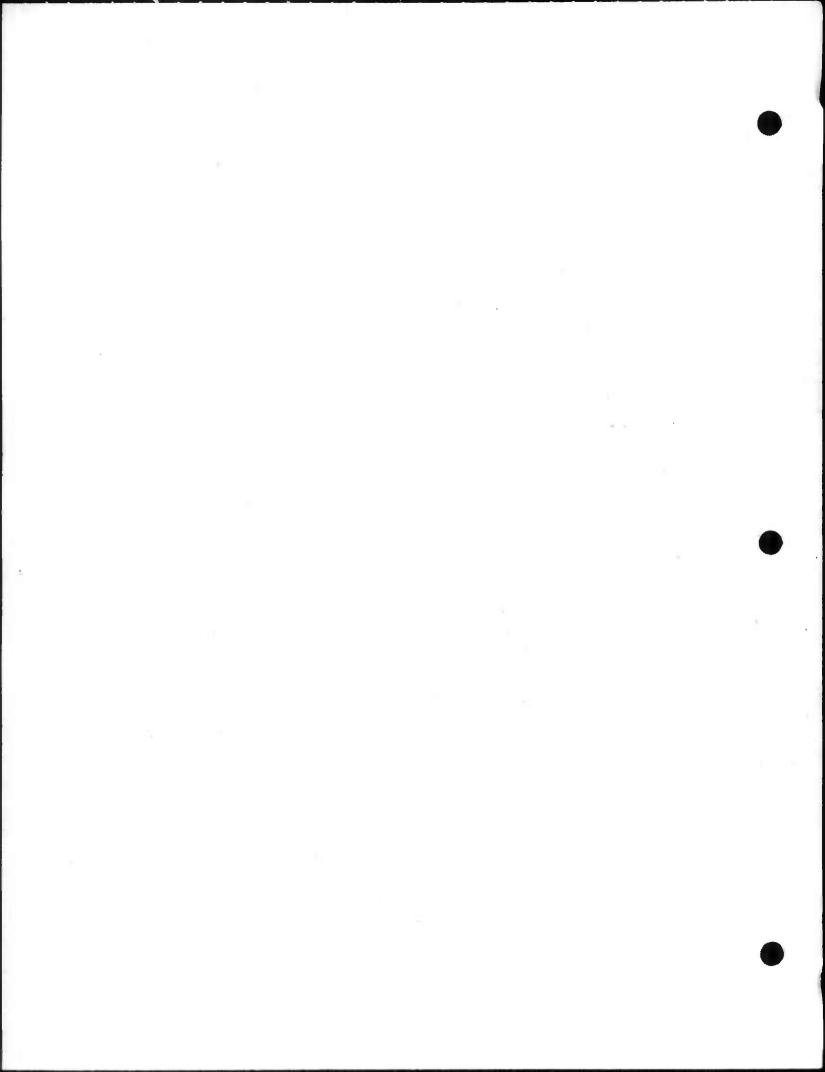
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FOR 1 . STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	:HIII	ICALE	OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest) Adolph Ma	rvin Na	ttel					2. DATE O	D.	AY	YEAR	3. TIME OF DEATH
	-							Octo	ober]	14,1	995	11:10am
	4. SOCIAL SECURITY NUMBER 310 22 2039	1 🖾 M 2 🗌 F	AGE (In yrs. less	birthday) YRS.	IF UNDER 1	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE 0 (Month, Jan	Day Year)	L928	Country	PLACE (State or Foreign
NC.	9e. FACILITY NAME (If not institution, give str 8808 Garfield S		96. COUNTY OF DEATH Bethesda 9c. COUNTY OF DI Montgon						ATH			
5	RESIDENCE OF DECEDENT											
RE	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION 10d. II							10d. INSIDE CITY	
LDI	Maryland Montg	omery		Bethesda								1 YES 2 NO
FUNERAL DIRECTOR	8808 Garfield S		101. ZIP CODE 10g. CITIZEN OF USA						ZEN OF W	HAT COUNTRY?		
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced De	FORCES? 15 IF YES, GIVE WAR	YES 2 N	NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black,						— American Indian, White, etc.		
											Whi	te
1	15. DECEDENT'S EDUC (Specify only highest grade of	ation completed)	(GA	ve kind of v	USUAL OCK	CUPATIO uring mo:	ON st of working	16b, I	CIND OF BU	SINESS/IND	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	Do NOT us								
¥		5+	Den	tis	t				neral		acti	ce
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S N			Surname)		
BE	Marcus Nattel						Regina	Kes	zler			
2	19a. INFORMANT'S NAME (Type/Print)		196	MAILING	ADDRESS	(Street a	nd Number or Rural	Route Numbe	r, City or Tow	n, State, Zip	Code)	
۴	Twila J. Nattel		sa	me a	as l	0 a	bove					
	20a. METHOD OF DISPOSITION		20b. PLACE A					DATE	20c. LO	CATION —	City or Toy	vn. State
	1 Remo 1 Donation 6 Other (Specify)	val from State	cometery crer	natory or of	her place!							aryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	MEHOL	an			D ADDRESS OF F		Troc.	V 1.1.	IC, M	aryrand
	ndenieku	Addus			Iv	es-	Pearso Churc	n Fui			mes	
	23 PART i. Enter the diseases, or co	emplications that c	eused the dea	ith. Do n	ot enter t	T T Z	de of dving au	the cords	A ZZ	2046	n at	I Assessings
	IMMEDIATE CAUSE (Final	let only one cause	on each line.				ac or cynig, acc	an Cardi	oc or reap	ratory arr	wat,	Approximate interval Between Onset and Death
	resulting in death) a. Globistome DUE TO (OR AS A CONSEQUENCE OF):										7 mg	
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											3 wies
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury			OLNOL OF	,							į
	that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSEO	UENCE OF):							
H	d.											
	PART II. Other algnificant conditions	contributing to de	eth but not re	sulting i	n the und	lechino	Cause alven in	Bort I I	4a. WAS AN	ALITODON	100	
EDICAL						onymg	Couse given in		PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
									2	T3 410		OF DEATH?
Σ.	DID TOBACCO USE CONTR	BUTE TO CALL	SE OF DEAT	H YF	S \square N	ОП	UNCERTAI	N IZI				1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	3.2.0			H (Check on		OITCLKIAI	4 KPI				
SIC	EXAMINER?	HOSPITAL:			OTHER:		11	1.0				
¥	27. MANNER OF DEATH	1 Inpetient 2 E		28b. TIME		ng Home	Residence			Latares		
	1 Netural 5 Pending	(Month, Day,		INJ		WOR		28d. DESC	RIBE HOW II	NJURY OCC	CURED	
B	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF II	MIRY - At box	- form -								
TED	4 Homicide 6 Could not be determined	building, atc	. (Specify)	10, 101 Ht, p	area, ractor	ry, orne		City or	ION (Street a Town, State)	nd Number	or Rural Ro	ute Number,
١٣	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	AN: To the best of my	knowledge dee	th occurre	d at the ti-	no data	and place and d	to the cours	(a) and =		-4	
COMPLET	(Check only one) 2 MEDICAL EXAMINER											and minimals of the latest
				gerio	., му орг				nu prace, and			
BE	29b. SIGNATURE AND TURE OF CONTIFIER	1	111				29c. LICENSE NU	WBER		29d. DATE	SIGNED (Month, Day, Year)
2	mole ///	Jun	1 ms				D35°	194		1	0-10	7-95
	30. NAME AND ADDRESS OF PERSON WHO											
	ZINDAM BUR	REU. 5	454 4	1150	0 2510	w /	ANZ 130	75,0	Heu	4 0	HASE	mn
- 1	31. DATE FILED (Month, Day 1945)	32 REGISTRAR'S	NATURE					,				70815



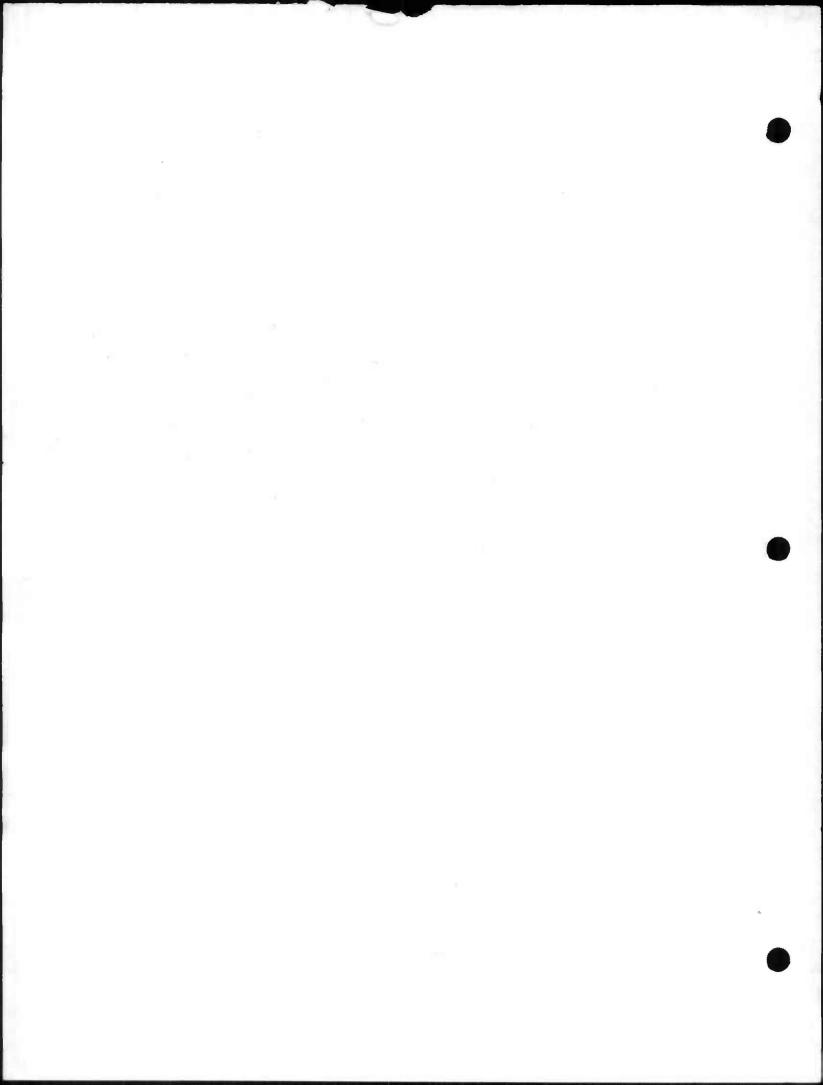
BALTIMORE, MARYLAND 21215-0020

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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPART			MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH			
	MERL	ROBERT	P/	ARKER			AV YEA	1 8 · 1111			
	4. SOCIAL SECURITY NUMBER 219-50-6880			IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	1946	BALTIMORE, MD			
_	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF OEAT										
DIRECTOR	500 Engle Avenue	3		Balt	imore		N/A				
EC	10e. STATE 10b. COUNTY	1	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY			
		n/a		BAL	TIMORE	1 TYES 2 NO					
FUNERAL	100. STREET AND NUMBER 500 ENGLE AVE	INUE		101.	21218	3	UNITE	D STATES			
BY FUN	11. MARITAL STATUS 1. Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN L FORCES? 1 _ YES IF YES, GIVE WAR OR DATE	2 V VO	13. WAS OEC If yes, spe 1 YES	ENOENT OF HISPAN scilly Cyben, Mexica 2 XO Specify	IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	6	ACE — American Indian, Black, White, etc.			
COMPLETED	15. OECEDENT'S EDU- (Specify only highest grade	CATION (**completed)	6e. DECEDENT'S U	rk done during mo.		16b. KIND OF BU	SINESS/INDUSTR	TY .			
2	Elementary/Secondary (0-12) 7 th	College (1-4 or 5+)	DISABL	310.0	ORER	var	ious ti	rades			
8	17. FATHER'S NAME (First, Middle, Last)		DIGNOL	LD CAL		ME (First, Middle, Melden		4440			
BE C	MERL PARKER				PAL	METTA RAS	SBERRY				
5	196. INFORMANT'S NAME (Type/Print) PALMETTA PA	ARKER	19b. MAILING A	ENGLE		9 BALTIMOF		RYLAND # 18			
	20e. METHOD OF DISPOSITION 1X XBuriel 2		LACEAND DATE OF ery, crematory or other ZION			1	CATION — City o	WE , MARYLAND			
	21. SIGNATURE OF FUHERAL SERVICE LIC		. Z10N	22. NAME AN	D ADORESS OF FA	CILITY		WE, MARTLAND			
	Def	1/2-5	28	MARCH 1101	FUNERAL E. NORTH	HOME EAST	r ALTTMORI	E, MD 21292			
	23. PARY I, Enter the diseases, or o	conglications that caused I	the weeth. Do No					Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition ALCONOLLOS SELECTION S										
-	resulting in death)	a. DUE TO (OR AS A C				VEDER		A LEUS!			
z	Sequentially list conditions, ALCONOLISM UYGG										
Ĕ	th any, leading to Immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or Injury that initiated events	c. DUE TO (OR AS A C	CONSEQUENCE OF)				,				
E	resulting in deeth) LAST	d									
AL	PART II. Other algnificent condition	is contributing to death but	not resulting in	the underlying	g cause given in	Pert I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
PHYSICIAN: MEDIC						1 YES 2		COMPLETION OF CAUSE OF DEATH?			
M	DID TODA CCO LICE COATT	DIDLETT TO CALLET OF	D-4-11 1/-	. 🗆	Y		,	1 TYES 2 NO			
AN	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERIAII						
SICI	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpet		OTHER:	a 5 X Residence	6 Other (Specify)					
¥	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ	•	28d. DEŞCRIBE HOW	INJURY OCCURE	D			
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY – building, etc. (Specify	- At home, ferm, at	reet, fectory, offic		281. LOCATION (Street City or Town, Stete)		iral Route Number,			
Solution of the determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ea stated.											
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI			NED (Month, Day, Year)			
) BE	Naman A	Scott III, M	. 4.		D344) = (9 - 9 5			
5	30. NAME AND ADDRESS OF PERSON WH NATHAN A. SCOTT	III. M.D.		CArD	212 02						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE	0	-,						
	OCT 2 01995	Jalia de Wilson	arlett								
								DHMH-18 Rev 1/89			



BALTIMORE, MARYLAND 21215-0020

31. DATE FILED (Month, Day, Year)

OCT 2 01995

2. REGISTRARIS SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ze hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TIEM: 8. PEK	r.n. rili										
1 - STATE REGISTRAR		STATE OF I					DEATH	MENTAL HYGIE REG. N			
1. DECEDENT'S NAME (FI	rst, Middle, Lest)			PIERCE				2. DATE OF DEATH MONTH OCTOBER	16,	1995	3. TIME OF DEATH 8:32 P M
4. SOCIAL SECURITY NU 220–14–7738		5. SEX	6. AGE (In yrs.		IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1924		IPLACE (State or Foreign TVVIRGINIA
9a. FACILITY NAME (If no	institution, give s	street and number)			9b. CITY,	TOWN C	R LOCATION OF DE		-	UNTY OF D	
THE JOHN	S HOPKI	NS HOSPI	TAL		BALT	CIMC	RE CITY		N	/A	
RESIDENCE OF D	ECEDENT										
THE JOHN RESIDENCE OF D 100. STATE Maryland	16b. COUNT	/A			ry, town of ltimo:		TION				10d, INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBE						101	. ZIP CODE		10g. CI	TIZEN OF V	VHAT COUNTRY?
821 N. Can	coline :	Street				:	21205		U	.S.A.	
821 N. Can 11. Marrital Status	_	12. WAS DECEDED	T EVER IN U.S.	ARMED				NIC ORIGIN? (Specify in, Puerto Ricen, etc.)	Yes or No-	14. RACI	E — American Indian, k, White, etc.
3 X Widowed 4 D			MAR OR DATES				NO Specif			Spec	
15. D (Specify	ECEDENT'S EDU		.16a	. DECEDENT'S	USUAL OCI			16b. KIND OF	BUSINESS/II	NDUSTRY	(30.14
Elementary/Secondary		College (1-4 or 5	+)	life. Do NOT u	ise retired.)						
llth				Cook				Cafet	eria		
17. FATHER'S NAME (First	Middle, Last)						18. MOTHER'S NA	ME (First, Middle, Maid	ien Sumame)		
Percy Jac	ckson						Olivia	Walker			
	E (Type/Print)			19b. MAILING	ADDRESS	(Street a	and Number or Rural	Route Number, City or	Town, State, 2	Zip Code)	
Cassandra	Pierce			821 1	N. Car	rol:	ine Stree	et/Baltim	ore,	MD 21	.205
20e. METHOD OF DISPOSITION 1 X Suriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemeter), crematory or other place) King Memorial Park 20c. LOCATION — City or Town, State 10-20 Randallstown, MD											
21. SIGNATURE OF FUNE	RAL SERVICE LI	CENSEE		, 110	22. N	AME A	ND ADDRESS OF FA	CILITY		LUCUM	,
V		1	100		Ma	rch	Funeral	Home Eas	st		
have	~ ~	m. C	vole								MD 21202
23. PART I. Enter the ahock, or IMMEDIATE CAUSE (haart fallure.	Complications the			not enter t	the mo	ede of dying, suc	h aa cardlec or re	apiratory a	irrest,	Approximate Interval Between Onset and Deatt
disease or condition resulting in death)		a. Cong	OF AS A COI	Heart		lun	2				3 years
Sequentially list con if any, leading to impose cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L	nediate LYING	bOUE TO	OR AS A COR	NSEOUENCE (DF):						
CAUSE (Disease or I that initiated eventa reaulting in death) L		DUE TO	OR AS A COL	NSEOUENCE (DF):						
<u></u>		d									
DID TOBACCO 25. WAS CASE REFERRE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	icant condition	na contributing to	o death but n	ot resulting	in the und	ierlyln	g cause given in	PER	AN AUTOPS FORMED?	Y 248	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<u> </u>											1 _ YES 2 _ NO
DID TOBACCO	USE CONT	RIBUTE TO CA	AUSE OF D	EATH Y	ES 🗆 N	10 [UNCERTAL	N 🗆			
25. WAS CASE REFERRE	TO MEDICAL		26. F	PLACE OF DE	ATH (Check o	nly one)					
1 TYES 2 NO		HOSPITAL:	□ ER/Outpatier	N 3 DOA	OTHER 4 □ Nura		ne 5 🗆 Residence	6 Other (Specify)			
	Pending	26a. DATE O (Month,	F INJURY Day, Year)	26b. Til	ME OF JURY M	W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HO	W INJURY C	CCURED	
2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28a. PLACE building	OF INJURY — A	At home, term,	atreet, facto	ory, offic	ca .	261. LOCATION (Str. City or Town, St		ber or Rural	Route Number,
toridon only								to the cause(a) and			
3			exerniteRION BR	wor investigat	ion, in my of	eniion, (a) and menner as stated.
296. SIGNATURE AND TI	TLE OF CERTUFIE	1	.4				29c. LICENSE NU		29d. D	ATE SIGNE	(Month, Day, Year)
20. NAME AND ADDRESS	~ ~	Jarohner	M	U			L96°	13	- (Dotok	per 18 1995
30. NAME AND ADDRESS	OF PERSON WI	HO COMPLETED CA		(ITEM 27) (Typ		1	Dale d	RIL	VC 440	(M)	71787

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5	that
D II	requires
ļ	MP
-	The
-	PHYSICIAN
NO COLATO	ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
2	L OF
	N

1	1. DECEDENT'S NAME (First, Middle, Last) Sand Chaze	M. Robins		E OF DEATH	2. DATE MONTE	DE OEATH DAY 15 95		EAR	TIME OF DEAT	DA
	4. SOCIAL SECURITY NUMBER 219-21-8250	5. SEX 8. AGE (in yrs.	-	ER 1 YEAR JF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE	OF BIRTH	0.		ACE (State or Fo	reign
CTOR	98. FACILITY NAME (If not institution, give st	HO(p) tul	9b. CIT	or, town on Location of o	EATH		9c. COUNTY	OF OEAT	TH	
DIPE	10a. STATE 10b. COUNTY	NA	10c. CITY, TOWN Balt	on Location Imore					d. INSIDE CITY LIMITS? YES 2	
VERAL	21 N. Bruce	Street		101. ZIP COOE	2-3		10g. CITIZEN	OF WH	S.A	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S., FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES	ARMED 13	I. WAS DECENDENT OF HISPA If yes, specify Cuben, Maxico 1 YES 2 NO Specifi	n, Puerto I		na or No 14	RACE	American India Phila, etc.	in,
PLETED	15. OECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	completed)	OECEOENT'S USUAL (Give kind of work done life. Do NOT use retired.	e during most of working	16b	KINO OF BI	h bul	TRY		
E COMPL	17. FATHER'S NAME (First, Middle, Lapti) 18. MOTHER'S NAME (First, Middle) Meiden Surname) Perek Kobinson 18. MOTHER'S NAME (First, Middle) Meiden Surname) Paro Kobinson									
TO B	19a. INFORMANT'S NAME (Type/Print) .	HOLLOMON	24 N	ss (Street and Number or Rural Bruce 5	Hue Num	ber, City or To	Balt	de)	d 212	2
	26a.METHOD OF OISPOSITION 1 Meurial 2 Cremetton 3 Ram 4 Donation 8 Other (Specify)	oval from State cemelery.	ce AND DATE OF DISPO	" Cemetery	10/19	E 20c. 1	ansdo	wn Town	nd Md	
	21. SIGNATURE OF FUNERAL SERVICE LIC	Ware	22	MATCH F. H. 4300 W.	West	t uh A	e Ba	No.	rd 21:	215
	23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Due to (OR AS A CON)	ne.	er the mode of dying, aud	ch aa care	diac or rea	piratory arres	l,	Approxim interval B Onset and 48 Nu	atwee
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
25	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CON:	SEQUENCE OF):							
ERTIFI	ACQUIRED IMMUNODEPICIENCY PUNDROMB PERFORMEO?									INDING: TO CAUSE
CERTIFI	ACQUIRED 11	MUNODERICIENCY	JYNDnoy	В	_	1 YES	2 NO	OF GEATH? 1 YES 2 NO		
MEDICAL CERTIFI	ACQUITED HE LEI OPPY DERICA DID TOBACCO USE CONTI	COMA RIBUTE TO CAUSE OF DI			N D	1 YES	2 NO		YES 2	NO
SICIAN: MEDICAL CERTIFI	ACQUIRED IN LEIONAY DE BAIR DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DINO	COMA RIBUTE TO CAUSE OF DI	ACE OF OEATH (Chec	ck only one)			2 🗌 NO		YES 2	NO
PHYSICIAN: MEDICAL CERTIFI	ACQUIRED IN LB/OMP4 DAIR DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 DINO 27. MANNER OF OEATH 1 DINSTURE 5 Pending	COMA RIBUTE TO CAUSE OF DI HOSPIAL:	ACE OF OEATH (Chec	ck only one)	8 🗆 Othe	er (Specify)	2 NO	1	YES 2	NO
SICIAN: MEDICAL CERTIFI	ACQUIRED IN LEI OFFY DEATH DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DINO 27. MANNER OF DEATH 1 DINSTURED 5 Pending	COMA RIBUTE TO CAUSE OF DI 26. PI HOSPITAL: 1 Dripetient 2 ER/Outpetient 280. DATE OF INJURY	ACE OF GEATH (Check 3 DOA 4 N 28b. TIME OF INJURY M	ck only one) ER: ursing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	8 Other	or (Specify)	I INJURY OCCUI	1 PED		NO

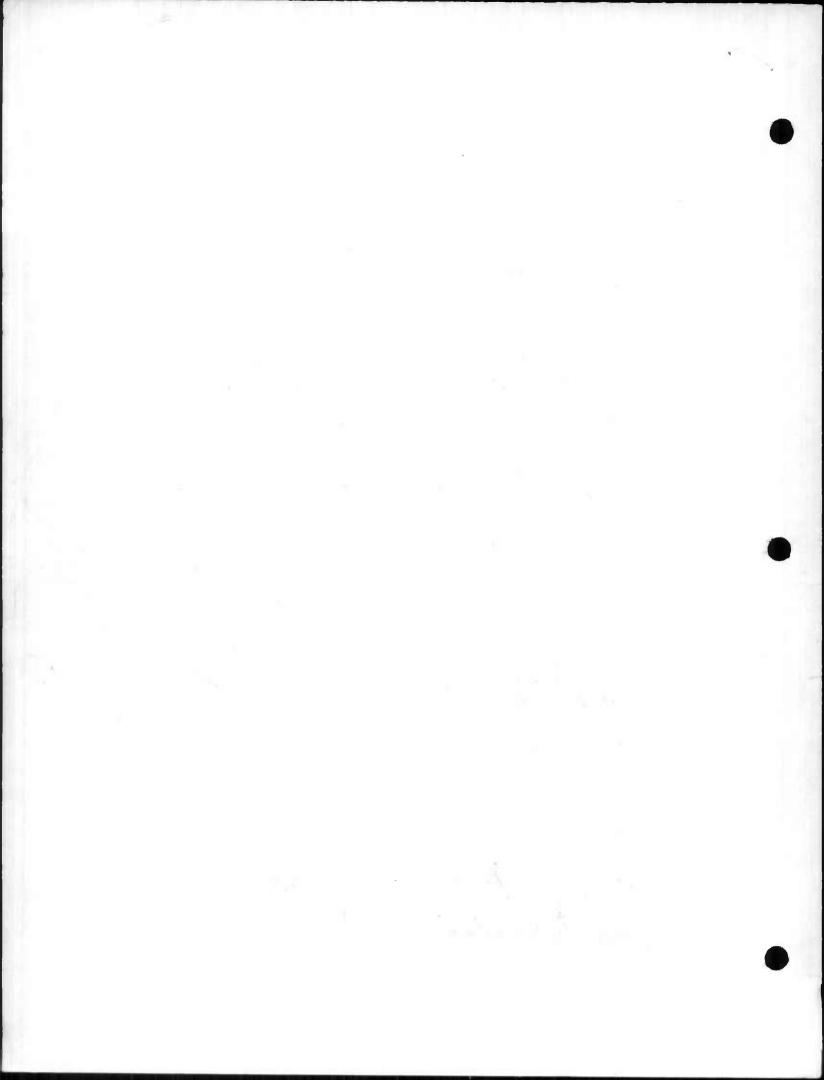
OEATH (1/EM 27) (Type, Print)

WAT. BAGMOUS

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JOHN FAREY MS 31. DATE FILEO (MO1995 Hoar) July OCT 2 1 1995



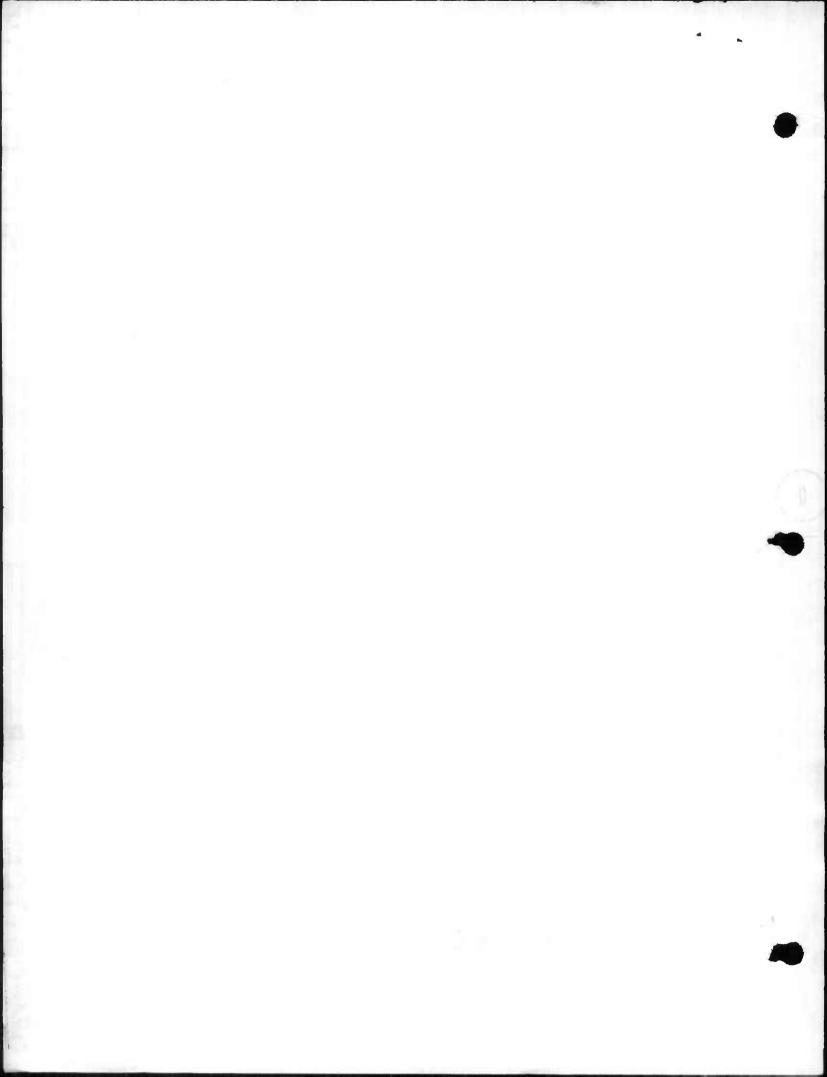
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o Stronger		notified
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In the lotter of		1 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Soudine.	I, cren	event
2000	or to burial, cremation, o	matic
your man	prior	trau
2	s after death with the State Dept. of Health and Mental Hygiene prior	othe
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2117	Ment	niun
2	and	W
Segretar	lealth	WS 3
100	6	sho
	Dept.	23
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	FOR	CTATE OF M	ADVI AND	PEDA	Y88541	. 05 11	£41 7 11	4110		111/0151	_	20	0190
	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF M		ERTIF						REG. NO.	Ė.		3. TIME OF DEATH
	Frederick L	<u> </u>							MONTH	D/	w /	YEAR	S. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Ia	SI birthday)	T	R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		BIRTHP	LACE (State or Foreign
	212-05-6602	1 x M 2 - F	95	YRS.	MONTHS	DAYS	HOURS	MIN.	Sent	, Day, Year) 14,	1900	Country)	higan
	9a. FACILITY NAME (If not institution, give at	reet and number)			9b. CIT	Y, TOWN O	R LOCATIO	ON OF DI		,		TY OF DE	
H	2507 Poplar Drive				I W	lood1	awn				Ba	ltimo	re
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT												
뿐	10a. STATE 10b. COUNTY					OR LOCAT							10d. INSIDE CITY LIMITS?
0		imore			Wood	lawn							1 YES 2 K NO
RAI	10e. STREET AND NUMBER					101	ZIP CODE				227.		HAT COUNTRY?
W	2507 Poplar Driv							2120					States
	11. MARITAL STATUS 1 Never Married 2 Married		YES 2 1	RMED NO	13.	If yes, spe	elfy Cuba	n, Maxica	in, Puarto F	? (Specify Yea lican, etc.)	or No—	14. RACE - Black,	- American Indian, White, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE W	AR OR DATES			1 TYES	2 👿 NO	Specif	y:			Specify	White
G	15. DECEDENT'S EDUC	CATION	18a. Di	ECEDENT'S	USUAL	CCUPATIO)N		18b.	KIND OF BU	SINESS/IND	USTRY	
ETI	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+) (A	Sive kind of a. Do NOT u	work done ise retired.)	during mo	si of workin	g					
COMPLETED		4 years		ginee	r					B.G.	& E.	Co.	
O	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, A	fiddle, Maiden			
BE C	Frederick William	m Rapson					Mar	y Ar	n C1	ark			
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a				er, City or Tow	n, State, Zip	Code)	
2	Mr. Frederick W. Rapson 4117 Font Hill Drive Ellicott City, MD 21042												
	20a. METHOD OF DISPOSITION 1 GV Burlai 2 Cremation 3 Removal from Stata 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)												
	4 Donation 8 Dother (Specify) Woodlawn Cemetery 10/23 Woodlawn, MD												
	21. SIGNATURE OF FONERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc.											T	
													MD 21133
-	23. PANT L. Enter the diseases, or o	complications that	ceueed the d	anth, Do									Approximate
	shock, or heart fellure. List only one cause on aach line												
	MMEDIATE CAUSE (Final	oth:	4.3						6400				
	resulting in death) s. HWAL SUBSEQUENCE OF:										9200		
~		the	- 10	sur	-								
ERTIFICATION	Sequentielly list conditions,	DUE TO	OR AS A CONSE	QUENCE C	P):								
S	cause. Enter UNDERLYING												
Ë	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSE	QUENCE C	P):								
H	resulting in death) LAST	d											
O	PART II. Other aignificant condition	s contributing to	death but not	regulting	In the u	nderlyln	2 001100 (nlven in	Dart I	24a, WAS AN	ALITODOV	245	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Depression			resulting	III LIIU G	naony m	9 00000 1	givon in		PERFO	RMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE
	THE THE STATE OF								- 1	1 _ YES 2	NO	1	OF DEATH?
Σ									- 1				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL					00 DI	405.05.0	F 2 T 1 1 10 1					
2	EXAMINER?	HOSPITAL:			ОТНЕ	R:	- 10		neck only or				
١٨S	1 VES 2 NO	1 Inpetient 2 I		28b. Til		28c. INJ		sidenca	8 Othe	r (Specify) SCRIBE HOW	N HIRV OC	CHRED	
	1 Natural 5 Pending	(Month, De		IN	JURY	WO 1	RK7	NO	200. DE	CHIBE HOW	NJUHT OC	CUMED	
BY	2 Accident Investigation	28a PLACE O	F INJURY — At h	ome ferm	etraat fa				284 1.00	ATION (Street	and Mumba	or Burnt Or	nuto Mumbar
6	3 Suicide 8 Could not be 4 Homicide determined	building,	atc. (Specify)	onio, iairii,	otioot, 10	otory, offic				or Town, State,		OF FIGHT FIC	outer recentled,
Ē	29a. CERTIFIER												
MPI	(Check only 1) CERTIFYING PHYSI	CIAN: To the best of											
COMPLETED	2 MENICAL EXAMINE		amination and/or	investigati	ion, in my	opinion, d	eeth occu	red at the	time, data	and place, a	nd due to th	ne cause(a)	and manner as stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIE	1/1	10 10				29c. LICI	ENSE NU			29d, DAT	_	(Month, Day, Year)
0	30 NAME AND ADDRESS OF DEDSON WIL	vune	641)				0	516	161			CCI	18 1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Van Mari OCT 2 01995

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Columbra mol



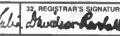
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ECORDS,	
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OF	
DIVISION	

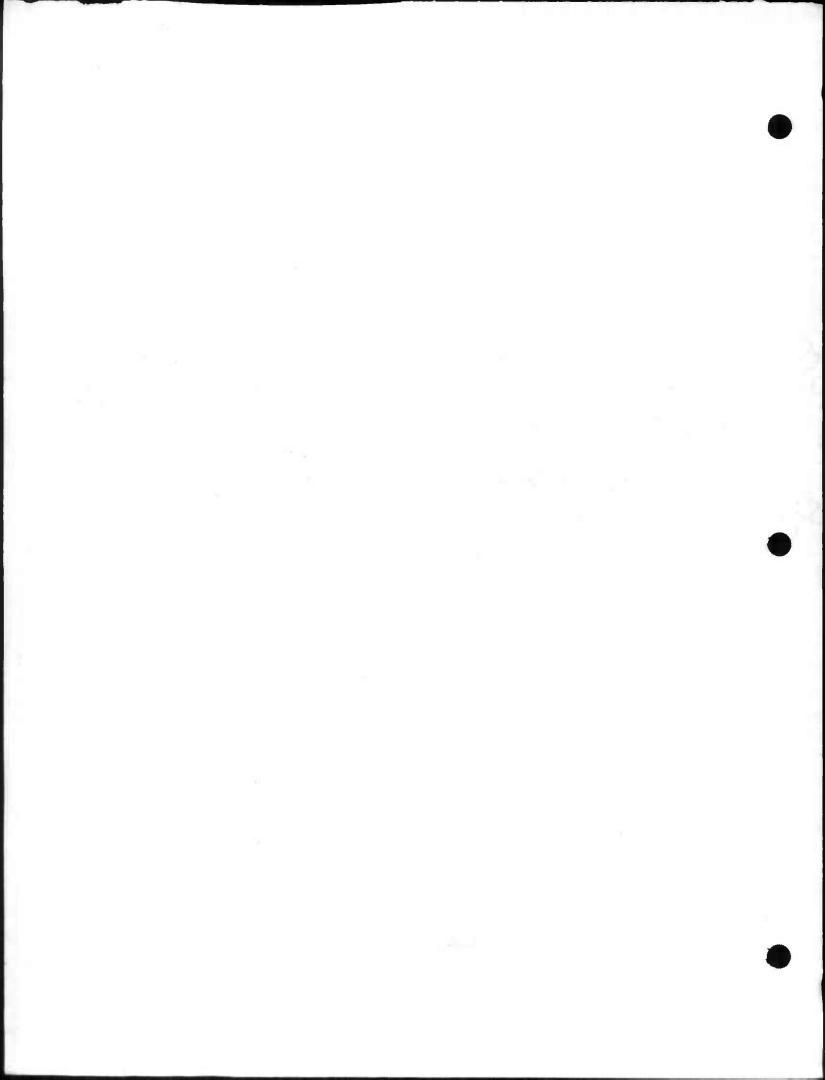
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
1. 0	DECEDENT'S NAME (First, Middle, Last)		2. DATE O	F DEATH DAY

	REGISTRAR		CER	TIFICATE	OF DEA	TH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEA	тн
- 1	Robby Cic	Robinso	nn .			October 18, 1995			1.10	7 M	
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birt		VEAR DE IMPE	R 24 HRS.	7. DATE OF BIRTH			1:10 PLACE (State or F	A M
		1-√2 M 2 □ F			DAYS HOURS	MIN.	(Month, Day, Year)		Country	y)	
	245-86-9455	Λ	45	HS.			August 23	1950	Nor	th Caro	lina
	9e. FACILITY NAME (If not institution, give :	street end number)		9b. CITY, 1	OWN OR LOCAT	ION OF D	EATH	9c. COUN	TY OF D	EATH	
CTOR	1505 Tunlaw Roa	d			Baltimo	re			n/a		
5	RESIDENCE OF DECEDENT								11/ 0		
DIRE	10e. STATE 10b. COUNT	Υ	10	c. CITY, TOWN OR	LOCATION					10d. INSIDE CIT	Y
5	Maryland	n/a		Balt:	imore					t XYES 2	NO .
4 1	10e. STREET AND NUMBER	-			10f. ZIP COI	DE		10g. CITIZ	EN OF W	HAT COUNTRY?	
FUNERAL	1505 Tunlaw Road	đ			2	1218			T	JSA	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED	13. W			NIC ORIGIN? (Specify Ye	or No.			llen
	1 Nover Merried 2 Merried		YES 2 NO	11	yes, specify Cub	en, Mexico	en, Puerto Rican, atc.)			American ind White, etc.	,
ž I	3 Widowed 4 Divorced	IF YES, GIVE W	AH OH DATES		☐ YES 2 X NO) Specii	y:		Spech		de l
ا ۾	15. DECEDENT'S EDU	JCATION	16a, DECED	ENT'S USUAL OCC	UPATION		16b. KIND OF BU	SINESS/INDI	ISTRY	Blac	:K
COMPLETED	(Specify only highest grade	e completed)	(Give k	ind of work done du NOT use retired.)	ring most of work	ing	TOOL KIND OF DO	OHIL SS/HIVE	Joini		
ا ڌِ	Elementary/Secondery (0-12)	College (1-4 or 5 +)								
Ž		6 years		Teache					1 Co	School	LSvs
3	17. FATHER'S NAME (First, Middle, Last)				18, MO	THER'S NA	ME (First, Middle, Maiden	Surname)			
N N	Cicero Robinson					Loui	se Arringt	on			
5	19e. INFORMANT'S NAME (Type/Print)		19b. M.	AILING ADDRESS	Street and Numb	er or Rural	Route Number, City or Tox	rn, Stete, Zip	Code)	27874	
-	Louise Robinson		Rou	te 1 I	361 sox		Scotland N	leck,	Nort	h Caro	lina
	20 METHOD OF DISPOSITION			DATE OF DISPOSIT	ION (Neme of			CATION — C			
	t Denation 5 Other (Specify)	noval from State	Mary s	Chanel	Cemete	erv	24 Sc	t land	No.	ck NC	
1	21. SIGNATURE OF FUNGRAL SERVICE LI	CENSEE	1:2027	22. N	AME AND ADDR	ESS OF FA	CILITNUTTER I	Tunera	al H	omes. T	nc.
	Kenninga	Hank,	^/	2	501 Gwy	nns	Falls Parl	cway		0.1.10.77	
	The state of	10099		B	altimo	ce, N		21216			
CERTIFICATION	abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa reaulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
2		u									
: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									R TO CAUSE	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	1		F DEATH (Check or		~=·(1/\					
<u> </u>	EXAMINER?	HOSPITAL:		OTHER			VIII				
2	1 YES 2 1 NO		ER/Outpatient 3 🗌			Residence	6 Other (Specify)				
	1 Nétural 5 Pending	28e. DATE OF (Month, De		Bb. TIME OF INJURY	Sc. INJURY AT WORK?	_	28d. DESCRIBE HOW	INJURY OCC	URED		
à l	2 Accident Investigation			M		□ NO					
	3 Suicide 8 Could not be	28e. PLACE Of building,	F INJURY — At home, atc. (Specify)	ferm, street, facto	y, office		28f. LOCATION (Street City or Town, State		or Aural F	Route Number,	
	4 Homicide determined										
COMPLETED	onal						to the cause(e) end me			o) end menner ee	stated.
	296. SIGNATURE AND TITLE OF CERTIFIE	ER O DOD			29C LI	CENSE NU	MBER	29d. DATE	SIGNED	(Month, Day, Year)
2	TVarcea 8a	neino			00	263	91	•	101	20/95	-
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	E OF DEATH TEM 2	(Type: Print)		4.1	0	,	- (01	
	30. NAME AND ADDRESS OF PERSON WI Marcia Lano MC 31. DATE FILED (Month, Day, Year)			Place	2 POB	No	403 Balt	inor	e/	6212	102
	OCT 2 01995	the devotes	R'S SIGNATURE								





2. DATE OF DEATH

STATE

REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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1760
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OF
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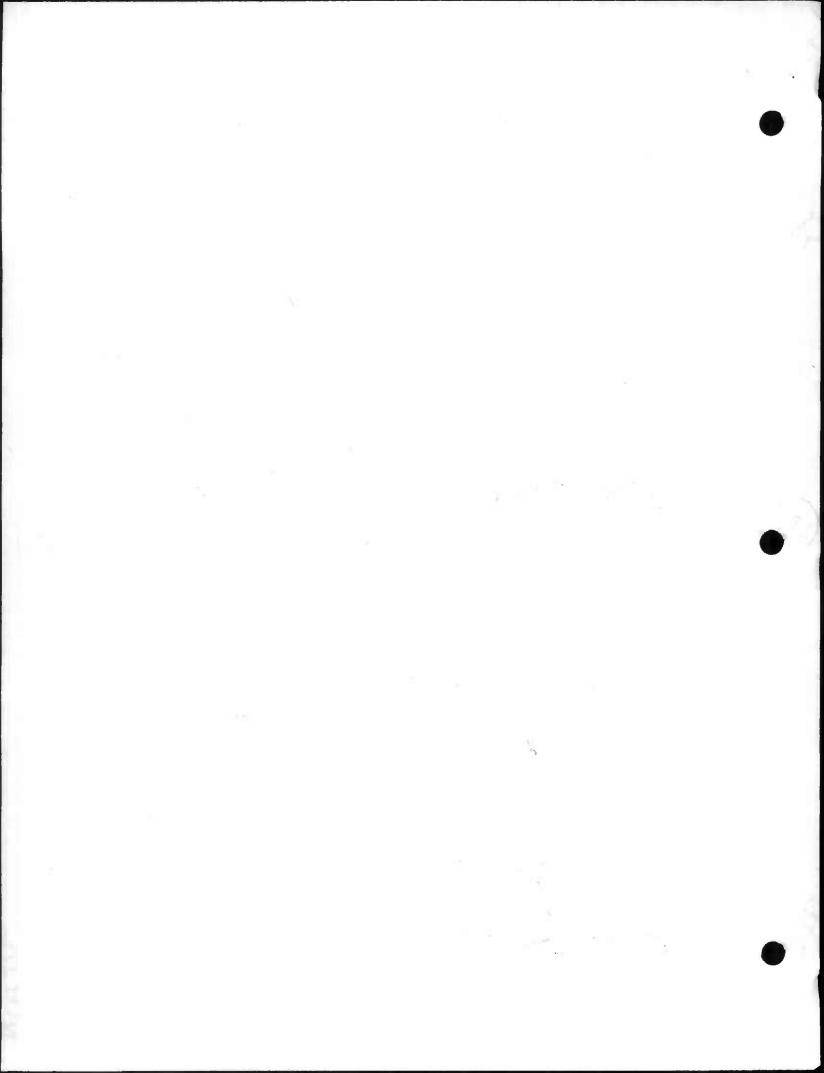
Margaret SMITH RAPHEL 12:19 ctober 15 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
DECEMBER 10, 1916 HARFORD CO., MD. HOURS 1 - M 2 F 220-09-5963 9a. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Pages 1, 2, 3 FRANKLIN SOLARE HOSPITAL BALTIMORE COUNTY Baltimore County 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE PERRY HALL 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9220 COWENTON AVENUE 21128 U.S.A. use as the burial-transit attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried BY Specify: 3 Widowed 4 Divorced WHITE ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify retained by the hospital or detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 HOMEMAKER HOUSEKEEPING - OWN HOME once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) FREDERICK NELSON SMITH ANNE CALLAHAN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7902 OMEGA COURT KINGSVILLE, MARYLAND 21087 2 ELLEN L. COLE 2 9 20a, METHOD OF DISPOSITION
1 X Buriel 2 Cremation 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of death. Page 6 may OATE 20c. LOCATION - City or Town, must STOCKETHY'S CHURCH CEM. OCTOBER 18,1995 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND AODRESS OF FACILITY
E.F. LASSAHN FUNERAL HOME, P.A. 11750 BELAIR ROAD KINGSVILLE, MARYLAND 21087-1351 n by the transmit **Hor** medical 23. PART i. Enter the diseased or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, spletaly filled in shock, or heart failure. List only one cause on each line. interval Batwe IMMEDIATE CAUSE (Fine) Onset and Death disease or condition 書 Atheros clar resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) in and corr to burisi, esecuted trauminite CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate attending physician 2 prior cause. Enter UNDERLYING death certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 signed by the atte Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 24s. WAS AN AUTOPSY PERFORMEO? 1 - YES 2 X NO seulines Shows 1 YES 2 NO been 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗷 PHYSICIAN: Dept. 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: Item State 1 YES 2 XNO OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify) the state 27. MANNER OF DEATN 26b. TIME OF 26s. DATE OF INJURY 26c. INJURY AT marked, 28d. DESCRIBE NOW INJURY OCCURED With this 1) Natural 5 Pending м 1 YES 2 NO BY After death 2 Accident Investigation ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) DIRECTOR: At hours after de item 28 is r 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 🗌 Homicide determined TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT
DE fied within 72 hours at IMPORTANT; If Item 2 29e. CERTIFIER
(Check only one)

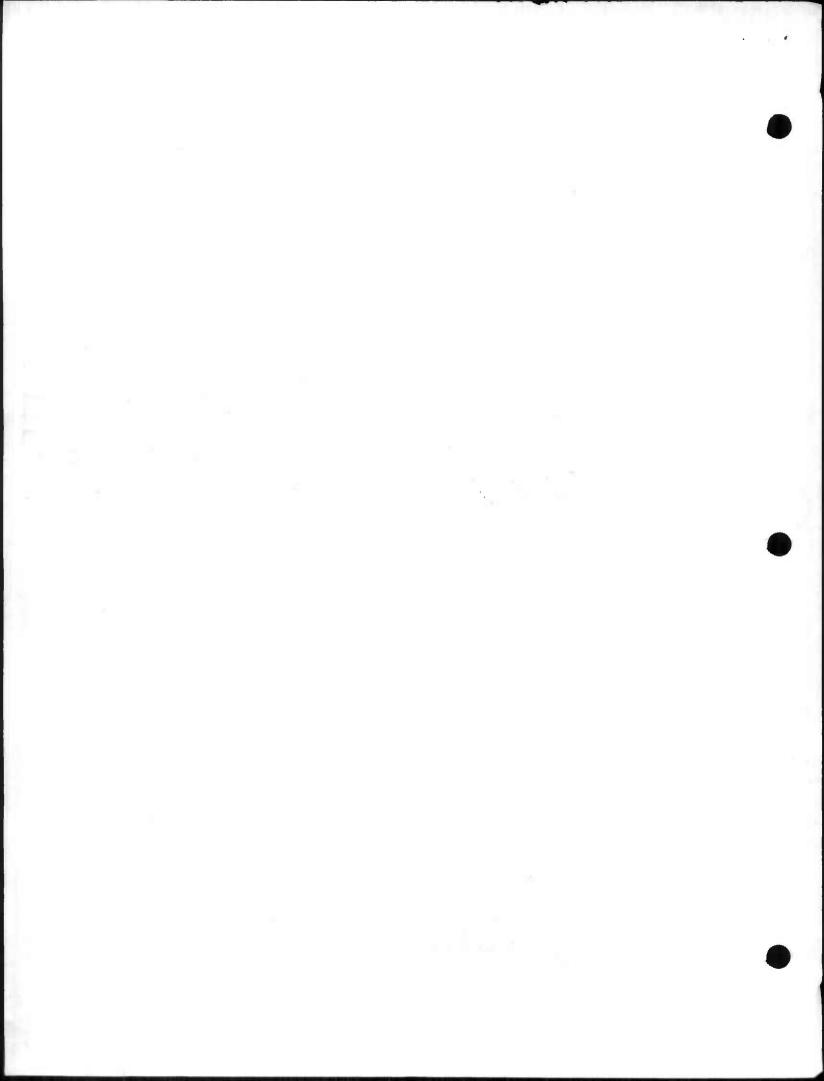
2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) end manner se atted. 296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month Day, Year) 29c. LICENSE NUMBER 8 Edeward 22848 lales 6 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Edward Seth Kraus M. D. White Sq. Bldg. Rossville Blvd. 21237 Suite 6 31. DATE FILED (Month, Day, Year)
OCT 2 0 1995 32 REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAI	L HYGIENI	E				
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATN	,	YEAR 3	. TIME OF DEATN		
								October 18, 1995 1:50				
	4. SOCIAL SECURITY NUMBER 216-05-5985	5-5985 MONTHS DAYS HOURS MIN. 10-44792-049. (141) 1020 COUR							Country)	ace (State or Foreign		
DIRECTOR	9a. FACILITY NAME (If not institution, give st 6416 Fair Oaks Ave.	treet and number)	91		or Location of DE Ore City	EATN		9c. COUNT	N/A	тн		
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT	ION				1	Dd. INSIDE CITY		
		N/A		Baltim	ore City				1	X VES 2 NO		
FUNERAL	6416 Fair Oaks Ave.			101	21214				J.S.A.	AT COUNTRY?		
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAY	2 NO	If yes, sp	ENDENT OF NISPAN ecity Cuban, Maxica 2 NO Specify	n, Puerto I		or No- 1	Black, 1	- American Indian, White, atc. White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. OECEDENT'S US (Give kind of won life. Do NOT use n Welder	k done during mo etired.)	ON st of working	16b	KIND OF BUS	to.City		rnment		
BE COM	17. FATHER'S NAME (First, Middle, Last) William J. Sheldon, Sr.				18. MOTHER'S NA Mary Logu		Middle, Maiden	Surname)		6		
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Lula E.(nee Folks	s) Sheldon	6416 Fa:	ir Oaks /	Ave. Baltin	nore,M	ber, City or Town Taryland	21214	Code)			
	20a. METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 Rem	oval from State 20b.	PLACE AND DATE OF	r place)		DAT		CATION — CI		1		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF TUNERAL SERVICE LICE	hely h	drison Fore	Leon	and J. Ri	UCK F	unera	gs Mill l Home ltimor	e, Ir	ryland nc. Maryland 212		
	23. PART I. Enter the diseases, or a shock, or heart fellure.	complications that coused	the deeth. Do not							Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition									Onset and Death		
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	Arcest UENCE OF:						minutes		
N	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF): Years											
ATIC	If any, reading to infinediate									Years		
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):										
	PART II. Other algnificant condition	ns contributing to death be	ut not resulting in	the underlyin	g cause given in	Part I.	24e. WAS AN	AUTOPSY	24b. V	/ERE AUTOPSY FINDINGS		
JICAL					PERFOR			ORMEO? AMAILABLE COMPLETIO		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC										☐ YES 2 ☐ NO		
AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES] UNCERTAI	N 🔲						
SICI	EXAMINER?	HOSPITAL:		THER:	ne 5 Residence							
HX	27. MANNER OF DEATN	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. IN.	JURY AT ORK?		SCRIBE NOW I	NJURY OCC	JREO			
ВУР	Netural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO							
	3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office 28t. I						28t, LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	and.	ICIAN: To the best of my knowl ER: On the basis of examination								and manner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	n o	0.0		29c. LICENSE NUI				-	Month, Day, Year)		
TO B	30. NAME AND ADDRESS OF PERSON WIN	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type. P	rint)	258	12	\	▶ 10	119	195		
	Howard Freeland		Morgan E		g Good Sa	amari	itan Ho	ospita	al 3	ord.		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA										
	UL 2 0 1333	my water	-49							DHMH-16 Rev 1/89		



Item# 1.G-film 728 per F.H 10/20/95 P.C

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the final manner of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR CERTIFICATE (F DEATH	REG. NO								
	1. DECEDENT'S NAME (First, Middle, Last) Peter Paul Sirochman		10 1	Ď ď	5 6 PM						
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 7 YRS. 1 MONTHS DA	YS HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year)	2 Po	HRTHPLACE (State or Foreign Country) 2NNSYLVANIA						
TOR		on or location of di altimore C		9c. COUNTY	N/A						
DIRECTOR	Maryland N/A 10c. City, Town OR L		timore Cit	ore City 10d. INSIDE CITY LIMITS?							
FUNERAL	100. STREET AND NUMBER 6526 Detroit Avenue	101. ZIP CODE	21222 United States								
B	1 Never Married 2 V Married FORCES? VX YES 2 NO It ye	DECENDENT OF HISPAI a, specify Cuban, Maxica YES 2 X NO Specif			RACE — American Indian, Black, White, etc. Specify: White						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Give kind of work done durin life. Do Nor use retired.] 12 Years General For	g most of working	16b. KIND OF BU								
M				cel Indi	ustry						
BE CO	17. FATHER'S NAME (First, Middle, Last) Peter Sirochman	Mary K	AME (First, Middle, Melder Tatt	Surname)							
10	190. INFORMANT'S NAME (Type/Print) Wrs. Catherine Sirochman 190. Malling address (St. 6526 Detro										
	20a, METHOD OF DISPOSITION **Without al 2 Cremation 3 Ramoval from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory or other place) 4 Donation 5 Other (Specify) Sacred Ht. of Jesus Cem. 10/20/95 Dundalk. Maryland										
	21. SIGNATURE OF THERAL SERVICE LICENSEE	E AND ADDRESS OF FA	reral Home 2. Dundal	of Dun	idalk, Inc.						
	28. PART. Enter the diseases, or complications that caused the death. Do not enter the										
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition SUNSIS										
	disease or condition reaulting in death) a. SUSSIS DUE TO (OR AS A CONSEQUENCE OF): SUSSISSISSISSISSISSISSISSISSISSISSISSISS										
ATION	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING Source To (or as a consequence of): DUE TO (or as a consequence of): MCL NULL TIL CON.										
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST										
	PART II. Other algnificant conditions contributing to death but not resulting in the under	tvina cause alven in	Part I. 24e. WAS AF	VAUTOBSV	24b, WERE AUTOPSY FINDINGS						
EDICAL	against out of the state of the	,,mg 02000 g.rom m		RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO		N 🗆		1 Tes 2 Ar No						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only EXAMINER) OTHER:	one)									
1YS		Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW	IN ILIBA OCCITA	ED.						
BY PI	1 Netural 5 Pending (Month, Day, Year) INJURY 2 Accident Investigation	WORK?									
	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, tarm, street, factory, building, etc. (Specify)	offica	281. LOCATION (Street City or Town, State		Rurel Route Number,						
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opini				suse(a) and manner as stated.						
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU		29d. DATE SI	GNED (Mgnth, Day, Year)						
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W. A. HOOGERWERF, DOHNS HOPMINS BOOYUI	9500		1 Juma	ee mo						
	31. DATE FILED MOON, Day year 1 32 PREGISTRAR'S SENATURE OCT 2 0 1995 Hull of wellow haveall		cin / ba								
	1 001 % 4 1000 / 1000										